PATIENT REGISTRATION

First Name: _____ **Last Name:** _____ **Middle Initial:** ___

Patient is: O Insurance Policy Holder O Responsible Party **Preferred Name:** _____

Responsible Party (*If someone other than the patient)*

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Social Security: _____

O Responsible Party is also a Policy Holder for Patient O Primary Insurance Policy Holder O Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Social Security: _____

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

E-mail: _____ O I would like to receive correspondences via e-mail.

Section 2

Employment Status: O Full Time O Part Time O Retired

Student Status: O Full Time O Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Hygienist: _____

Carrier ID: _____ Pref. Pharmacy: _____

Emergency Contact: _____

Emergency Phone: _____

Credit Card #: _____

Expiration Date: _____ CID: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: O Self O Spouse O Child O Other

Insured Soc. Sec:

Employer:

Address:

Address 2:

City, State, Zip: