PATIENT REGISTRATION

ID: _____ Chart ID: _____

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

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party General Dentist: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial : _____
Address: _____ Address 2: _____
City, State, Zip: _____ Cell Phone: _____
Home Phone: _____ Work Phone: _____ Ext: _____
Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

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

Patient Information

Address: _____ Address 2: _____
City, State, Zip: _____ Cell Phone: _____
Home Phone: _____ Work Phone: _____ Ext: _____
Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

Sex: ○ Male ○ Female Martial Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

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

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID:_____
Employer ID: _____
Carrier ID: _____

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other
Insured Soc . Sec.: _____ Insured Birth Date: _____
Employer: _____

Employer: _____
Address: _____
Address 2: _____
City, State, Zip: _____

Ins. Company: _____
Address: _____
Address 2: _____
City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other
Insured Soc . Sec.: _____ Insured Birth Date: _____
Employer: _____

Employer: _____
Address: _____
Address 2: _____
City, State, Zip: _____

Ins. Company: _____
Address: _____
Address 2: _____
City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____