PATIENT REGISTRATION

Chart ID: _____

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

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

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

Address:_____ Address 2: _____

City, State, Zip:_____ Pager: _____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular: _____

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:_____ Pager: _____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular: _____

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

Birth Date:_____ Age:_____ Soc. Sec:_____ Drivers Lic: _____ 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:_____ Pref. Dentist: _____

Employer ID:_____ Pref. Pharmacy:_____

Carrier ID:_____ Pref. Hyg.: _____

Section 3

OK to call at work: _____

Primary Insurance Information

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

Insured Soc. Sec:_____ Insured Birth Date: _____

Employer:_____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits:_____.00 Rem. Deduct:_____.00

Secondary Insurance Information

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

Insured Soc. Sec:_____ Insured Birth Date: _____

Employer:_____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits:_____.00 Rem. Deduct:_____.00