Patient Registration

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address2:

City: State: Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Social Security: Drivers License:

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

Patient Information

Address: Address2:

City: State: Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Social Security: Drivers License:

Email: ☐ 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

Referred By:

Previous Dentist:

Emergency Contact:

Emergency Contact #:

Military Pay Grade:

Primary Insurance Information

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

Insured Soc. Sec.: Insured Birth Date:

Employer: Insurance Company:

Address: Address:

Address2: Address2:

City: State: Zip: 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: Insurance Company:

Address: Address:

Address2: Address2:

City: State: Zip: City: State: Zip:

Rem. Benefits: Rem. Deduct.:

Print Form