

## PATIENT REGISTRATION

ID: Chart ID:  
First Name: Last Name: Middle Initial:

Preferred Name:

Patient is :  Responsible Party  Policy Holder

**Responsible Party:** ( if someone other than the patient )

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #: Drivers Lic#:

Responsible Party is Policy Holder for Patient  Primary Policy Holder  Secondary Policy Holder

**Patient Information:**

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

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

Birth date: Social Security #: Drivers Lic#:

E-mail:  I would like to receive email correspondences

**Patient Information (section 2):**

Employment Status:  Full Time  Part Time  Self Employed  Retired  Unemployed

Student Status:  Full Time  Part Time

Preferred Dentist: Preferred Hygienist: Preferred Pharmacy:

Referred By:

Medicaid ID:

**Primary Insurance Information:**

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

Employer ID: Carrier ID:

Insured Social Security #: Insured Birth date:

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

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

**Secondary Insurance Information:**

Name of Insured:

Relationship to Insured: Self Spouse Child Other

Employer ID:

Carrier ID:

Insured Social Security #:

Insured Birth date:

Employer:

Insurance Company:

Address:

Address:

Address 2:

Address 2:

City, State, Zip:

City, State, Zip: