PATIENT REGISTRATION

ID: 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: Divers 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:

Employer ID:

Carrier ID:

Pref. Dentist

Pref. Pharmacy

Pref. Hyg

Section 3

Emergency Contac:

Emergency Phone:

Relationship to Pt:

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: Rem. Deduct:

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: Rem. Deduct: