

## 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: \_\_\_\_\_ 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

Referred By: \_\_\_\_\_  
Previous Dentist: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Emergency Contact #: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_

### 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