PATIENT REGISTRATION

First Name: Click here to enter text.	Last Name: Click here to enter text.	Middle Initial: Click here to enter text.
Patient is: ☐ Policy Holder ☐Responsible party	Preferred Name:Click here to enter text.	
ID:Click here to enter text.	Chart ID:Click here to enter text.	

Responsible Party (If someone other than the patient):

First Name: Click here to enter text.	Last Name: Click here to enter text.	Middle Initial: Click here to enter text.
Address: Click here to enter text.	City, State, Zip: Click here to enter text.	
Home Phone: Click here to enter text.	Cellular: Click here to enter text.	Work Phone: Click here to enter text. Ext:Click here to enter text.
Birth Date: Click here to enter text.	Drivers Lic: Click here to enter text.	Soc Sec:Click here to enter text.
☐Responsible Party is also a Policy Holder for Patient	☐Primary Insurance Policy Holder	☐Secondary Insurance Policy Holder

Patient Information:

Address: Click here to enter text.		City, State, Zip: Click here to enter text.	
Home Phone: Click here to enter text.	Cellular: Click here to enter text.		Work Phone: Click here to enter text. Ext: Click here to enter text.
Sex: ☐Female ☐Male	Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐ Widowed		
Birth Date: Click here to enter text.	Age:Click here to enter text.	Soc Sec: Click here to enter text.	Drivers Lic: Click here to enter text.
E-mail: Click here to enter text.		☐I would like to receive correspondences via E-mail	

Employment Status: ☐Full Time ☐Part Time ☐Retired Student Status: ☐Full Time ☐Part Time	Emergency Contact: Click here to enter text. Phone Number: Click here to enter text.
Medicaid ID: Click here to enter text.	Pref. Dentist: Click here to enter text.
Employer ID:Click here to enter text.	Pref. Pharmacy: Click here to enter text.
Carrier ID:Click here to enter text.	Pref. Hygienist: Click here to enter text.

Primary Insurance Information:

Name of Insured:Click here to enter text.	Relationship to Insured: ☐Self ☐Spouse ☐ Child ☐Other
Insured Soc. Sec: Click here to enter text.	Insured Birth Date: Click here to enter text.
Employer: Click here to enter text.	Ins. Company: Click here to enter text.
Employer Address:Click here to enter text.	Ins. Address: Click here to enter text.
City, State, Zip: Click here to enter text.	City, State, Zip: Click here to enter text.

Secondary Insurance Information:

Name of Insured:	Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Insured Soc. Sec: Click here to enter text.	Insured Birth Date: Click here to enter text.
Employer: Click here to enter text.	Ins. Company: Click here to enter text.
Employer Address:Click here to enter text.	Ins. Address: Click here to enter text.
City, State, Zip: Click here to enter text.	City, State, Zip: Click here to enter text.