

## PATIENT REGISTRATION

First Name: \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Patient is:  Policy Holder  Responsible Party

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

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

**Patient Information:**

Address: \_\_\_\_\_

City \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Widowed

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-Mail: \_\_\_\_\_  I would like to receive correspondence via e-mail.

**Referred by:** \_\_\_\_\_

**Employment Status:**  Full time  Part time  Retired Cell Phone: \_\_\_\_\_

**Student Status:**  Full time  Part time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg: \_\_\_\_\_

**Primary Insurance Information:**

Name of Insured: \_\_\_\_\_ Relationship to Patient  Self  Spouse  Child  Other

Insured Soc Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Benefits: \_\_\_\_\_ .00 Deductible: \_\_\_\_\_ .00

**Secondary Insurance Information:**

Name of Insured: \_\_\_\_\_ Relationship to Patient  Self  Spouse  Child  Other

Insured Soc Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Benefits: \_\_\_\_\_ .00 Deductible: \_\_\_\_\_ .00