

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

**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, and 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, and Zip: \_\_\_\_\_