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 ───   ─── Section 3 ───

Employment Status: ○ Full Time   ○ Part Time   ○ Retired   Referred By:: _____

Student Status: ○ Full Time   ○ Part Time   Credit Card #:: _____

Medicaid ID: Pref. Dentist: Expiration Date:: _____

                                                       Emergency Contact:: _____

Employer ID: _____   Pref. Pharmacy: _____   Emergency #:: _____

Carrier ID: _____   Pref. Hyg.: _____

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