

# Patient Registration

TODAY'S DATE \_\_\_\_\_

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

**First Name** \_\_\_\_\_ **Last Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_

Other Dentists if applicable \_\_\_\_\_

Other Physician Name \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

## Responsible Party (If someone other than the patient) \_\_\_\_\_

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

Street Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Driver License \_\_\_\_\_

## Patient Information \_\_\_\_\_

Street Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Male  Female  Married  Single  Divorced  Separated  Widowed

Birth Date \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Driver License \_\_\_\_\_

E-mail \_\_\_\_\_ Spouse Name \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_

Employment Status  Full Time  Part Time  Retired Height Feet \_\_\_\_\_ Inches \_\_\_\_\_

Student Status  Full Time  Part Time Weight \_\_\_\_\_

Medicaid ID \_\_\_\_\_ Preferred Dentist \_\_\_\_\_

Employer ID \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_

Carrier ID \_\_\_\_\_ Preferred Hygienist \_\_\_\_\_

## INSURANCE INFORMATION

### Primary Insurance Information \_\_\_\_\_

First Name of Insured \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Policy/Group No. \_\_\_\_\_ Relationship to insured  Self  Spouse

Insurance ID No. \_\_\_\_\_  Child  Other

Insured Soc Sec No. \_\_\_\_\_ Insured Birth Date \_\_\_\_\_

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

*Insured Address if different than patient's* Street Address \_\_\_\_\_

Street Address \_\_\_\_\_

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

Telephone \_\_\_\_\_

**Secondary Insurance Information**

First Name of Insured \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Policy/Group No. \_\_\_\_\_ Relationship to insured  Self  Spouse

Insurance ID No. \_\_\_\_\_  Child  Other

Insured Soc Sec No. \_\_\_\_\_ Insured Birth Date \_\_\_\_\_

Employer \_\_\_\_\_

Ins. Company \_\_\_\_\_

*Insured Address if different than patient's*

Street Address \_\_\_\_\_

Street Address \_\_\_\_\_

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

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

Telephone \_\_\_\_\_