

Date: \_\_\_\_\_

### PATIENT REGISTRATION

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

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Patient Is:  Policy Holder  
 Responsible Party

Responsible Party (if someone other than the patient) \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

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

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

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

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: \_\_\_\_\_

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

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_

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

#### Section 2

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

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

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

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

#### Section 3

Pharmacy Name: \_\_\_\_\_

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

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

Cell Phone #: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Fluoride: \_\_\_\_\_

#### Primary Insurance Information

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

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

Employer City, State, Zip: \_\_\_\_\_ Employer Address 2: \_\_\_\_\_

Ins. Company: \_\_\_\_\_ Ins. Co. Address: \_\_\_\_\_

Ins. Co. City, State, Zip: \_\_\_\_\_ Ins. Co. Address 2: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

#### Secondary Insurance Information

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

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

Employer City, State, Zip: \_\_\_\_\_ Employer Address 2: \_\_\_\_\_

Ins. Company: \_\_\_\_\_ Ins. Co. Address: \_\_\_\_\_

Ins. Co. City, State, Zip: \_\_\_\_\_ Ins. Co. Address 2: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00