

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: _____ Cell: _____

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 ---

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

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

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondence via e-mail

--- Section 2 --- Section 3 ---

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: _____

Emergency Contact Information
Name: _____
Phone #: _____
Name: _____
Phone #: _____

--- Primary Insurance Information ---

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Ins. Company: _____
Address: _____
Address 2: _____
City, State, Zip: _____

Very Important!

Who may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I will be sure to inform this office of any changes. **X** _____ Intial