PATIENT REGISTRATION

Chart ID: _____

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

Patient is: ☐Policy Holder ☐Responsible Party Preferred Name: _____

Patient Information

Address: _____

City, State, Zip: _____

Cellular Phone: _____ Home Phone: _____ Work Phone: _____ Ext: _____

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

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

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Responsible Party (if someone other than the patient)

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

Address: _____

City, State, Zip: _____

Cellular Phone: _____ Home Phone: _____ Work Phone: _____ Ext: _____

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

☐Responsible Party is also a Policy Holder for Patient ☐Primary Insurance Policy Holder ☐Secondary Insurance Policy Holder

Primary Insurance Information

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Insurance Company: _____

Name of Secondary Insurance (if applicable): _____

Last dental Exam and X-Rays: _____

Last dental Cleaning: _____

Who were you referred by? _____

Emergency Contact Name: _____ **Phone Number:** _____