PATIENT REGISTRATION

ID: _____ Chart ID: _____

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

Patient Is: ☐ Policy Holder

☐ Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____

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

Birth Date: _____ Social Security: _____ Drivers License: _____

◯ 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: _____ Cell Phone: _____

Sex: ◯ Male ◯ Female Marital ◯ Married ◯ Single ◯ Divorced ◯ Seperated ◯ Widowed

Birth Date: _____ Age: _____ Social Security: _____ Drivers License: _____

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

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

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Prefered Dentist: _____

Employer ID: _____ Prefered Pharmacy: _____

Carrier ID: _____ Prefered Hyg.:_____

Section 3

Emergency Contact: _____

Phone Number: _____

Refered By (Circle One)

Smiley O'Riley Train/Building TV/Radio

Yellow Pages Internet State Fair

Friend/Family _____

Other _____

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

Complete medical history on reverse side.