## **PATIENT REGISTRATION**

ID:	Chart ID:			
First Name:		_ Last Name:		Middle Initial:
Patient Is: Policy Holder				
Responsible Party				
-Responsible Party (if someone othe				
First Name:		_ Last Name: _		Middle Initial:
Address:			Address 2:	
City, State, Zip:				
Home Phone:	Work Phone	:	E	xt: Cell Phone:
Birth Date:	Social Security:			Drivers License:
Responsible Party is also a Poli	cy Holder for Patient	O Primary	Insurance Policy H	older Secondary Insurance Policy Holder
-Patient Information ————————————————————————————————————				
Address:			Address 2:	
City:			Stat	e: Zip:
Home Phone:	Work Phone	:	E	ext: Cell Phone:
Sex: Male Female	Marital	Married	◯ Single ◯	Divorced Seperated Widowed
Birth Date:	Age: So	cial Security: _		Drivers License:
Responsible Party is also a Poli	cy Holder for Patient	O Primary	Insurance Policy H	older Secondary Insurance Policy Holder
E-Mail:				I would like to receive correspondence via e-mail.
Section 2		0		Section 3
Employment Status: Full Time	_	Retired		Emergency Contact:
Student Status: Full Time	•			Phone Number:
Medicaid ID:	Prefered Dentist:			Refered By (Circle One)
	5 ( )5			Smiley O'Riley Train/Building TV/Radio Yellow Pages Internet State Fair
Employer ID:	_ Prefered Pharmacy:			9
Carrier ID:	Profored Llva :			Friend/Family
Camer ID.	_ Freiered Hyg			Other
Primary Insurance Information —				0 0 0
Name of Insured:		Re	elationship to Insure	d: O Self Spouse Child Other
Insured Soc. Sec.:		Ins	ured Birth Date:	
Employer:				
Address:				
Address 2:			Address 2:	
City, State, Zip:			City, State, Zip:	
Rem. Benefits:	<u>.00</u> Rem. De	educt:	.00	<u>)</u>
Secondary Insurance Information				
Name of Insured:		Re	lationship to Insure	d: Self Spouse Child Other
Insured Soc. Sec.:				
Employer:				
Address:				
Address 2:				
City, State, Zip:				
Rem. Benefits:			.00	
			<u>.oc</u>	<u>-</u>

Complete medical history on reverse side.