PATIENT REGISTERATION

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:** _____ **Cellular:** _____

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 _____

Address: _____ **Address 2 :** _____

City: _____ **State/ Zip:** _____ **Pager:** _____

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

Sex: ◯ **Male** ◯ **Female** **Marital Status:** ◯ **Married** ◯ **Single** ◯ **Divorced** ◯ **Separated** ◯ **Windowed**

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

E-mail: _____ ☐ **I would like to receive correspondences 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. Hyp.:** _____

Check patient notes: _____

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:** _____

City, State, Zip: _____ **City, State, Zip:** _____

Rem. Benefits: _____.00 **Rem. Deduct:** _____.00