

# 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: \_\_\_\_\_ 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  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

## Section 2

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: \_\_\_\_\_

## Section 3

Emergency Contact: \_\_\_\_\_

Emergency Phone #: \_\_\_\_\_

Your Employer Name: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_

Spouse Emp Name: \_\_\_\_\_

Spouse Emp Phone #: \_\_\_\_\_

## 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