

Patient registration

First Name Last Name

Preferred Name Middle Initial

Address

City State Zip

Primary Phone Secondary Phone

Email Drivers License

Birth Date Age Social Security Number

Preferred Dentist Preferred Hygienist

Preferred Pharmacy

Additional Information/Comments

Insured/responsible party (if different from patient)

First Name Last Name

Preferred Name Middle Initial

Address

City State Zip

Primary Phone Secondary Phone

Email Drivers License

Birth Date Age Social Security Number

Patient ID

Chart ID

Medicaid ID

Employer ID

Member ID

Carrier ID

Patient is:

- Primary policy holder
- Secondary policy holder
- Responsible party

Responsible Party is:

- Primary policy holder
- Secondary policy holder

Primary insurance information

Employer

Insurance Company

Employer Address

Insurance Company Address

City, State, Zip

City, State, Zip

Employer Phone

Insurance Company Phone

Benefits

Deductible

Secondary insurance information

Employer

Insurance Company

Employer Address

Insurance Company Address

City, State, Zip

City, State, Zip

Employer Phone

Insurance Company Phone

Benefits

Deductible

Relationship to Insured:

- Self
- Spouse
- Child
- Other _____

Sex:

- Male
- Female

Marital Status:

- Married
- Single
- Divorced
- Separated
- Widowed

Employment Status:

- Full Time
- Part Time
- Retired

Student Status:

- Full Time
- Part Time



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