

Website Patient Registration

ID _____ Chart ID _____

First Name _____ Last Name _____

Patient Is: Policy Holder Responsible Party

Responsible Party (if someone other than the patient)

First Name _____ Last Name _____

Address: _____

City: _____ State: _____ Zip: _____ Pager: _____

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

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

Responsible Party is also a Poly Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address: _____

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

No post-resins: _____

Primary Insurance Information

Name of Insured: _____

Relationship to Patient: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Secondary Insurance Information

Name of Insured: _____

Relationship to Patient: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

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