Print Form

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PATIENT REGISTRATION

First Name :_____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

☐ Responsible Person is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy holder

Patient Information

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

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

Email Address: _____ ☐ I would like to receive correspondences via email.

Emergency Contact: _____ Emergency Phone: _____ Credit Card: _____

Employment Status: ☐ Part-Time ☐ Full-time ☐ Retired Student Status: ☐ Part-Time ☐ Full-time

Medicaid ID: _____ Employer ID: _____ Carrier ID: _____

Pref. Dentist: _____ Pref. Pharmacy: _____ Pref. Hyg.: _____

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: $_____ Rem. Deduct.: $_____

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: $_____ Rem. Deduct.: $_____