

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 correspondence via e-mail.

Section 2: _____ Section 3: _____
Employment Status: Full Time Part Time Retired OCCUPATION: _____
Student Status: Full Time Part Time EMERGENCY CONTACT: _____
Medicaid ID: _____ Pref. Dentist: _____ CONTACT PHONE: _____
Employer ID: _____ Pref. Pharmacy: _____ WHO REFERRED YOU?: _____
Campus ID: _____ Pref. Hyg: _____

Primary Insurance Information
Name of Insured: _____ Relationship to Patient: 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 Patient: 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