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 Policy 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

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

Reset Print