

Date:



**PATIENT REGISTRATION FORM**

PATIENT INFORMATION					
Last Name:		First Name:		Middle Initial:	Preferred Name:
Birthdate:	Age:	Sex: <input type="radio"/> F <input type="radio"/> M	Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed		
Address:		City:		State:	Zip Code:
Social Security No.:		Home phone no.:		Cell phone no.:	
Employment Status: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Student			Student Status: <input type="radio"/> Full Time <input type="radio"/> Part Time		
Email Address: <input type="checkbox"/> I would like to receive correspondences via email.					
Medicaid ID:	Prof. Dentist:	Employer ID:		Prof. Pharmacy:	
Carrier ID:	Prof. Hyg:	Patient is: <input type="radio"/> Policy Holder <input type="radio"/> Responsible Party			
Responsible Party Information (if someone other than the patient)					
Last Name:		First Name:		Middle Initial:	
Address:		City:		State:	Zip Code:
Home Phone:		Work Phone:	Ext:	Cell Phone:	
Birthdate:	Social Security No.:		Drivers Lic:		
<input type="checkbox"/> Responsible Party is also a Policy Holder for Patient		<input type="checkbox"/> Primary Insurance Policy Holder		<input type="checkbox"/> Secondary Insurance Policy Holder	
Additional Comments:					
PRIMARY INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Name of Insured:			Relationship to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other		
Insured Social Security No.:			Insured Birthdate:		
Employer: _____			Insurance Company: _____		
Address: _____			Address: _____		
City, State, Zip: _____			City, State, Zip: _____		
Remaining Benefits: _____ .00			Remaining Deductable: _____ .00		
SECONDARY INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Name of Insured:			Relationship to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other		
Insured Social Security No.:			Insured Birthdate:		
Employer: _____			Insurance Company: _____		
Address: _____			Address: _____		
City, State, Zip: _____			City, State, Zip: _____		
Remaining Benefits: _____ .00			Remaining Deductable: _____ .00		
IN CASE OF EMERGENCY					
Name:		Relationship:		Home phone:	Work phone:
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.					
_____ Patient/Guardian signature				_____ Date	

For office use only:

ID: \_\_\_\_\_

Chart ID: \_\_\_\_\_