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