TIME 3:01 PM DATE 4/9/2014

## **PATIENT REGISTRATION**

	ID:	Chart ID:						
Responsible Party (If someone other than the patient)   First Name:	First Name:	Last Name:				Middle Initial:		
Rasponsible Party (if someone other than the patient)			Preferred N	ame:				
Address   Address								
Address   Address	First Name:							
City   State   Zip:								
Birth Date:								
○ Responsible Party is also a Policy Holder for Patient   ○ Primary Insurance Policy Holder         ○ Secondary Insurance Policy Holder           Patient Information         Address 2:           Address:           Address 2:           City:           State / Zip:           Pager:           Home Phone:           Work Phone:           Ext.         Collular:           Sex:           Male           Female           Marital Status:           Single           Divorced           Separated           Widowed           Birth Date:           Age:           Soc. Sec:           Drivers Lic:           Divorced           Separated           Widowed           Birth Date:           Age:           Soc. Sec:           Drivers Lic:           Drivers Lic:           Drivers Lic:           Employers License #:           Drivers License #:<								
Responsible Party is also a Policy Holder for Patient Information   Raddress	Birth Date:	Soc Sec	:		Drive	ers Lic:		
Address	O Responsible Party	is also a Policy Holder for Patie	nt O Primary	Insurance Po				
State / Zip:	Patient Information							
Nome Phone								
Sex	City:		_ State / Zip:			Pager:		
Birth Date:	Home Phone:	Work Phone	:		Ext:	Cellular:		
Nould like to receive correspondences via e-mail.   Section 2   Section 2   Section 3	Sex:	○ Female	Marital Status:	Married	○ Single	O Divorced	○ Separated ○ Widowed	
Section 2	Birth Date: -	Age:	Soc. Sec:_			Drivers Lic:		
Employment Status:	E-mail:			I would lil	ke to receive co	orrespondences vi	a e-mail.	
Student Status:   Full Time   Part Time	Section 2							
Student Status:   Full Time   Part Time   Pref. Dentist:   Spouse's Name:   Emergency Contact:   Parents Name:   Emergency Contact:   Parents Name:   Parent	Employment Status:	Full Time Part Time	Retired					
Medicaid ID:         Pref. Dentist:         Spouse's Name:         Emergency Contact:         Emergency Contact:         Pref. Pharmacy:         Parents Name:         Parents Name:         Pref. Pharmacy:         Parents Name:         Pref. Pharmacy:         Parents Name:         Pref. Pharmacy:         Parents Name:         Pref. Pharmacy:         Pref. Pharmacy: <td>Student Status:</td> <td>ull Time Part Time</td> <td></td> <td></td> <td></td> <td></td> <td></td>	Student Status:	ull Time Part Time						
Employer ID:	Medicaid ID:	Pref Der	ntiet.					
Employer ID:         Pref. Pharmacy:         Parents Name:			itiot.					
Primary Insurance Information  Name of Insured:  Insured Soc. Sec:  Insured Birth Date:  Employer:  Address:  Address 2:  City,State,Zip:  Rem. Benefits:  .00 Rem. Deduct:  Insured Birth Date:  Relationship to Insured:  Address 2:  City,State,Zip:  Rem. Benefits:  .00 Rem. Deduct:  Insured Birth Date:  Relationship to Insured:  Self Spouse Child Other  Relationship to Insured:  Spouse Child Other  Insured Soc. Sec:  Insured Birth Date:  Employer:  Address:  Address 2:  Address 2:  Address 2:  Address 2:  Address 2:  City,State,Zip:  City,State,Zip:  City,State,Zip:  City,State,Zip:  City,State,Zip:  City,State,Zip:  City,State,Zip:  City,State,Zip:  City,State,Zip:	Employer ID:	Pref. Pha	rmacy:					
Name of Insured:    Relationship to Insured:   Self   Spouse   Child   Other	Carrier ID:	Pref. Hyg	.:					
Insured Soc. Sec:	Primary Insurance Infor	mation						
Employer:       Address:       Address:       Address:       Address:       Address:       Address 2:       City,State,Zip:       City,State,Zip:       City,State,Zip:       City,State,Zip:       Rem. Deduct:       .00       Rem. Deduct:       .00       Rem. Deduct:       .00       Relationship to Insured:       Self       Spouse       Child       Other         Insured Soc. Sec:       Insured Birth Date:       Ins. Company:       Address:       Address:       Address:       Address:       Address:       Address:       City,State,Zip:       City,State,Zip: </td <td>Name of Insured:</td> <td></td> <td></td> <td>Rela</td> <td>tionship to Insu</td> <td>ured: Self (</td> <td>Spouse Child Other</td>	Name of Insured:			Rela	tionship to Insu	ured: Self (	Spouse Child Other	
Address:	Insured Soc. Sec:		Insured Birth D	Date:				
Address 2:	Employer:			_   Ins. Co	mpany:			
City,State,Zip:	Address:			_	Address:			
City,State,Zip:	Address 2:	Address 2:						
Rem. Benefits:								
Name of Insured:  Insured Soc. Sec:  Insured Birth Date:  Employer:  Address:  Address 2:  City,State,Zip:  Relationship to Insured: Self Spouse Child Other  Insured Soc. Secfic Shouse Child Other  Insured Birth Date:  Insured Birth Date:  Address:  Address:  Address:  City,State,Zip:  City,State,Zip:								
Insured Soc. Sec:         Insured Birth Date:           Employer:         Ins. Company:           Address:         Address:           Address 2:         Address 2:           City,State,Zip:         City,State,Zip:	Secondary Insurance In	formation						
Insured Soc. Sec:         Insured Birth Date:           Employer:         Ins. Company:           Address:         Address:           Address 2:         Address 2:           City,State,Zip:         City,State,Zip:	Name of Insured:			Rela	tionship to Insu	ured: Self (	Spouse Child Other	
Employer:         Ins. Company:           Address:         Address:           Address 2:         Address 2:           City,State,Zip:         City,State,Zip:								
Address 2:         Address 2:           City, State, Zip:         City, State, Zip:								
City,State,Zip: City,State,Zip:	Address:			_	Address:			
City,State,Zip: City,State,Zip:	Address 2:			_   A	ddress 2:			