

## 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