

PATIENT REGISTRATION



advanced
PROSTHODONTIC SPECIALISTS

ID: _____ Chart ID: _____
First Name: _____ Last Name: _____ Middle Initial: _____
Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient)
First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
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: _____ Address 2: _____
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
Previous Dentist: _____
Emergency Contact: _____
Emergency Contact #: _____

Primary Insurance Information
Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City,State,Zip: _____ City,State,Zip: _____
Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information
Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City,State,Zip: _____ City,State,Zip: _____
Rem. Benefits: _____ .00 Rem. Deduct: _____ .00