TIME 04:39 PM DATE 3/6/2014 PATIENT REGISTRATION

		PATIENT REGIST	KATION			
ID:	Chart ID:					
First Name:		Last Name:			Middle Initial:	
Patient Is: Po	olicy Holder Responsible Party	Preferred Name:				
Responsible	e 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:			Driver	s Lic:	
	Princer, Leaves et al. 20 Police, Holder for Police t					
Responsible Pa	arty is also a Policy Holder for Patient	Primary Insurance Policy	/ Holder		econdary Insurance Policy Holder	
Patient Infor	rmation —					
Address:		Address 2:				
City:		State / Zip:			Pager:	
Home Phone:	Work Phone:			Ext:	Cellular:	
Sex: M	fale Female	Marital Status: Marrie	ed Singl	e Divorced	Separated Widowed	
Birth Date:	Age:	Soc Sec:		Drivers	s Lic:	
E-mail:	I would like to receive correspondences via e-mail.					
	Section 2				- Section 3 -	
Employmen Status		Retired		Dra	Referred Byevious Dentist	
Student Status					gency Contact	
Medicaid ID	Pref. Den	tist:		Emerge	ncy Contact #	
Employer ID	Pref. Pharma	acy:				
Carrier ID	Pref. F	lyg:				
Primary Insu	urance Information —					
Name of Insured		Pa	lationshin to Ir	sured: Self	Spouse Child Other	
Insured Soc. Sec		Insured Birth Date:	ationship to in	isuredSeri	spouseciniuotilei	
Employer			Ins. Compa	anv:		
Address	Address:					
Address 2			Addres			
City, State, Zip						
Rem. Benefits		. Deduct:	- ',',',			
Secondary I	nsurance Information —					
Name of Insured		Re	lationship to In	sured: Self	Spouse Child Other	
Insured Soc. Sec		Insured Birth Date:				
Employer			Ins. Compa			
Address			Addr			
Address 2			Addres			
City, State, Zip) :		City, State, 2	Zip:		

Rem. Deduct:

Rem. Benefits: