ivorydental

PATIENT REGISTRATION FORM

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

First Name: _____ Last Name: _____ Middle Initial: _____

Address 1: _____ 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 1: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Age: _____ Drivers Lic: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

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.: _____

Credit Card: _____ Exp Date: _____ Emer Ph: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address1: _____ Address1: _____

Address2: _____ Address2: _____

City / State / Zip: _____ City / State / Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address1: _____ Address1: _____

Address2: _____ Address2: _____

City / State / Zip: _____ City / State / Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00