Advanced Restorative Dentistry

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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.:

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

Patient's Signature:

Date:

Guardian's Signature:

Date: