TIME 06:28 PM DATE 1/15/2016 PATIENT REGISTRATION

| ID: Chart ID: | | | |
|---|---------------------------------|-------------------------|--------------------------------|
| First Name: | Last Name: | | Middle Initial: |
| Patient Is: Policy Holder Responsible Party | Preferred Name: | | |
| Responsible Party (if someone other than the patient) — | | | |
| First Name: | Last Name: | | Middle Initial: |
| Address: | Address 2: | | |
| City, State, Zip: | | | Pager: |
| Home Work Phone: | | Ext: | Cellular: |
| Phone: — Soc Sec: | | Drivers L | ic: |
| | 7 | | |
| Responsible Party is also a Policy Holder for Patient | Primary Insurance Policy Holder | Seco | ondary Insurance Policy Holder |
| Patient Information — | | | |
| Address: | Address 2: | | |
| City: | State / Zip: | | Pager: |
| Home Work Phone: | | Ext: | Cellular: |
| Sex: Male Female | Marital Status: Married Singl | e Divorced | Separated Widowed |
| Birth Date: Age: | Soc Sec: | Drivers L | ic: |
| E-mail: I would like to receive correspondences via e-mail. | | | |
| Section 2 | | | Section 3 |
| Employment Full Time Part Time Status: | Retired | | eferred By |
| Student Status: Full Time Part Time | | | ous Dentist cy Contact |
| Medicaid ID: Pref. Denti | st: | Emergency | / Contact # |
| Employer ID: Pref. Pharmac | ey: | | |
| Carrier ID: Pref. Hy | /g: | | |
| Deisson Insurance Information | | | |
| Primary Insurance Information — | | | |
| Name of Insured: | Relationship to Ir | nsured: Self S | Spouse Child Other |
| Insured Soc. Sec: | Insured Birth Date: | | |
| Employer: | | Ins. Company: Address: | |
| Address: | | Address 2: | |
| Address 2: | | | |
| City, State, Zip: Rem. Benefits: Rem. | City, State, | Zip: | |
| Rem. Benefits: Rem. Deduct: | | | |
| Secondary Insurance Information — | | | |
| Name of Insured: | Relationship to Ir | nsured: Self | Spouse Child Other |
| Insured Soc. Sec: Insured Birth Date: | | | |
| Employer: | Ins. Comp. | any: | |
| Address: | Addı | ress: | |
| Address 2: | Addres | ss 2: | |
| City, State, Zip: | City, State, | Zip: | |
| Rem. Benefits: Rem. | Deduct: | | |