PATIENT REGISTRATION

ID: 17406   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 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: GAYLORD   State / Zip: MI   49735   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 —————————— Section 3 ——————

Employment Status: ☐ Full Time   ☐ Part Time   ☐ Retired

Student Status: ☐ Full Time   ☐ Part Time

Medicaid ID: Pref. Dentist: REBEKAH SHEPPARD

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg: AMANDA M. COLLIER

CELL PHONE
PHARMACY NUMBER
PHARMACY NAME
OTHER PHONE
PAGER

—— 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: $0.00   Rem. Deduct: $0.00

—— 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: $0.00   Rem. Deduct: $0.00