## **Website Patient Registration**

ID			_ Chart ID								
First Name			Last Name								
Patient Is: Policy	Holder	Responsible	Party								
Responsible Party (i	f someone of	ther than the pa	atient)								
First Name	nme Last Name										
Address:											
City:	State:		Zip:		_ Pager:						
Home Phone:	Work Phone:			_ Ext:	Cellular:						
Birth Date:	Soc. Sec: Drivers Lic:										
Responsible P	arty is also a P	olicy Holder for F	atient								
Primary Insura	ance Policy Ho	lder									
Secondary Ins	urance Policy I	Holder									
Patient Information											
Address:											
City:		State:	Zi	p:	Pager:						
Home Phone:	\	Work Phone:		_ Ext:	Cellular:						
Sex:	Male	Female									
Marital Status:	Married	Single	Divorced	Separated	Widowed						
Birth Date:	Age: Sc		c. Sec: Dr		Drivers Lic:						
E-mail:			I wou	ıld like to receive	correspondences via e	e-mail					
Section 2											
Employment Status:	Full Time		Part Time Retired		d						
Student Status:	Full Time		Part Time								
Medicaid ID:			Pı	ref. Dentist:							
Employer ID:	Pref. Pharmacy:										
Carrier ID:	Pref. Hyg.:										

## Section 3

## **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:						
				Zip:		
Rem. Benefits:		.00	Rem. Deduc	t:	.00	
Secondary Insurance Info	ormation					
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. Deduc	t:	.00	