TIM␣   PE␣   DATE

PATIENT REGISTRATION

ID _____   Char _____

First _____   Last N _____   Middle _____

☐ Pati ☐ Policy Ho ☐ Responsi   Preferre _____

☐ Responsible Party (if som...)

First _____   Last N _____   Middle _____

Addr _____   Addre _____

City St _____   Pag _____

Ho _____   Work Ph _____   Exs _____   Cell _____

Pho _____

Birt f _____   Soc _____   Driver _____

☐ Responsible Party is also a   ☐ Primary Insurance Policy H   ☐ Secondary Insurance

---

☐ Patient I

Addr _____   Addre _____

Cit _____   State _____   Pag _____

Ho _____   Work Ph _____   Exs _____   Cell _____

Pho _____

Se ☐ Male ☐ Femal   Marita ☐ Marri ☐ Singl ☐ Divorc ☐ Spar ☐ Widowed

Birt f _____   Age _____   Soc _____   Driver _____

Ema _____   ☐ I would like to receive c

Section   **Section**

Employ ☐ Full Time ☐ Part Tim ☐ Retired | Referr _____
Sta _____ Studen ☐ Full Time ☐ Part Tim | Previou _____
Medica _____   Pref De _____ | Last Den _____
Employe _____   Pref Ph _____ | Last Denta _____
Carri _____   Pref _____ | Type of C _____ / Pain or _____

Primary Insuranc

Name of I _____   Relationsh ☐ Self ☐ Spou ☐ Chil ☐ Othe

Insured _____   Insured B _____

Emplo _____ | Ins Co _____

Addr _____ | Addr _____

Addre _____ | Addre _____

City St _____ | City St _____

Rem Be _____ Rem De _____

Secondary Insur

Name of I _____   Relationsh ☐ Self ☐ Spou ☐ Chil ☐ Othe

Insured _____   Insured B _____

Emplo _____ | Ins Co _____

Addr _____ | Addr _____

Addre _____ | Addre _____

City St _____ | City St _____

Rem Be _____ Rem De _____