Red Hill Dental Office - Quakertown Dental Office

PATIENT REGISTRATION

ID:_____ Chart ID:_____ Date: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Referred by: _____

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. Hygienist: _____

Section 3

Emergency Contact: _____

Relationship to Patient: _____

Emergency Phone #: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Dental Insurance Policy Holder ◯ Secondary Dental Insurance Policy Holder

Primary Dental Insurance Information

Name of Policy Holder: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Policy Holder's Soc. Sec: _____ Policy Holder's Birth Date: _____

Policy Holder's Address if Different Than Patients:

Address: _____ Insurance Company: _____

Address 2: _____ Insurance ID #: _____

City, State, Zip: _____ Group #: _____

Employer: _____ Address: _____

City, State, Zip: _____

Secondary Dental Insurance Information

Name of Policy Holder: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Policy Holder's Soc. Sec: _____ Policy Holder's Birth Date: _____

Policy Holder's Address if Different Than Patients:

Address: _____ Insurance Company: _____

Address 2: _____ Insurance ID #: _____

City, State, Zip: _____ Group #: _____

Employer: _____ Address: _____

City, State, Zip: _____