

Patient Registration

ID: _____ Chart ID: _____
 First Name: _____ Last Name: _____ Middle Initial: _____
 Patient is: Policy Holder Preferred Name: _____
 Responsible Party

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: _____ 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, State, Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Cellular: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____
 Email: _____ I would like to receive correspondences via email

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. Hyg.: _____

Section 3

Medical History: _____
 Premedication: _____
 Insufficient funds: _____
 Dr. Forge only: _____
 Incomplete chart: _____
 Difficult Patient: _____
 Difficult Anesthesia: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc Sec: _____ Insured Birth Date: _____
 Employer: _____ Insurance Company _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City, State, Zip: _____ City, State, Zip: _____
 Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc Sec: _____ Insured Birth Date: _____
 Employer: _____ Insurance Company _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City, State, Zip: _____ City, State, Zip: _____
 Rem. Benefits: .00 Rem. Deduct: .00