Shaendfield Smiles

www.shaenfieldsmiles.com

PATIENT REGISTRATION

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

Patient is : □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

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

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

E-mail: _____ Referred By: _____

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○ Full Time ○ Part Time

Primary Insurance Information:

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Name of Insured:_____ Member ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Emp. Phone Number: _____ Ins. Phone Number: _____

Medicaid/CHIP Information:

Plan Name: _____ Member ID: _____

Physician Name: _____ Phone Number: _____