EVERGREEN DENTAL, PA
PATIENT REGISTRATION

ID:_____ Chart ID: _____

PATIENT INFORMATION

First Name:_____ Last Name: _____

Address:_____ Address 2: _____

City:_____ State/Zip:_____ Pager: _____

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 correspondeces via e-mail.

SECTION 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Physician #: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy:_____

SECTION 3

Emergency Number: _____

Insurance Group#: _____

RESPONSIBLE PARTY (if someone other than the patient)

First Name: _____ Last Name:_____

Address:_____ Address 2: _____

City:_____ State/Zip: _____ Pager: _____

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

Birth Date:_____ Age: _____ Soc. Sec.#:_____ Drivers Lic.#:_____

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

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PRIMARY DENTAL INSURANCE INFORMATION

First Name:_____ Relationship to Patient: ☐ 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

First Name:_____ Relationship to Patient: ☐ 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
