PIKE LAKE DENTAL PATIENT REGISTRATION FORM

PATIENT NAME ______________________ BIRTH DATE __________ DATE ____________

ID __________ CHART ID __________

LAST NAME ______________________ MIDDLE INITIAL __________ PREFERRED NAME __________

PATIENT IS: ☐ POLICY HOLDER ☐ 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 ______________ EXT ________ CELL ______________

BIRTH DATE ______________ SOC SEC ______________ DRIVERS LIC ______________

☐ RESPONSIBLE PARTY IS ALSO A POLICY HOLDER FOR PATIENT

☐ PRIMARY INSURANCE POLICY HOLDER

☐ SECONDARY INSURANCE POLICY HOLDER

EMERGENCY CONTACT 1 ______________________ EMERGENCY CONTACT 2 ______________________

PATIENT INFORMATION

ADDRESS: ____

ADDRESS 2: ____

CITY ______________ STATE ________ ZIP ________ PAGER ________

HOME PHONE ______________

WORK PHONE ______________ EXT ________ CELL ______________

☐ 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.

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: ______________________

PIKE LAKE
DENTAL CENTER

PIKE LAKE DENTAL PATIENT REGISTRATION FORM

PRIMARY INSURANCE INFORMATION

NAME OF INSURED ______________________ RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURED SOC. SEC ______________________ INSURED BIRTH DATE ______________________

EMPLOYER ______________________

ADDRESS ______________________

ADDRESS 2 ______________________

CITY ____________ STATE ______ ZIP ____________

REM. BENEFITS ____________ REM. DEDUCT ____________

INS. COMPANY ______________________

ADDRESS ______________________

ADDRESS 2 ______________________

CITY ____________ STATE ______ ZIP ____________

SECONDARY INSURANCE INFORMATION

NAME OF INSURED ______________________ RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURED SOC. SEC ______________________ INSURED BIRTH DATE ______________________

EMPLOYER ______________________

ADDRESS ______________________

ADDRESS 2 ______________________

CITY ____________ STATE ______ ZIP ____________

REM. BENEFITS ____________ REM. DEDUCT ____________

INS. COMPANY ______________________

ADDRESS ______________________

ADDRESS 2 ______________________

CITY ____________ STATE ______ ZIP ____________

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