family dentistry
OF NEOSHO

PATIENT REGISTRATION

ID: _____

Chart ID: _____

Patient Name: _____ Preferred Name: _____
Last First Middle Initial

Responsible Party Information

Name: _____
Last First Middle Initial

Address: _____ Wk Phone: _____
Street City State Zip

Home or Cell Phone: _____ Birth Date: _____ Social Security #: _____

Email: _____ Drivers Lic: _____

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

Patient Information

Address: _____ Sex: ◯ Male ◯ Female
Street City State Zip

Home phone: _____ Work phone: _____ Cell phone: _____

Birth Date: _____ Age: _____ Social Security #: _____ Drivers Lic: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Email: _____ ◯ 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. Hyg: _____

Section 3

Employer: _____

Care Credit Acct #: _____

Care Credit Limit: _____

Credit Card: _____

CC Type: _____ Expires: _____ SEC: _____

Referred By: _____

Celebration: _____

Primary Insurance Information

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

Name of Insured: _____ DOB: _____ Social Security #: _____

Insurance company: _____ Group #: _____ Member ID: _____

Insc. Co. address: _____ Insc. Co. Phone: _____
Street City State Zip

Policy holder's employer: _____
Name Street City State Zip

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

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

Name of Insured: _____ DOB: _____ Social Security #: _____

Insurance company: _____ Group #: _____ Member ID: _____

Insc. Co. address: _____ Insc. Co. Phone: _____
Street City State Zip

Policy holder's employer: _____
Name Street City State Zip

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00