Five Star Dentists

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ 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: _____ 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: _____ 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 correspondences via e-mail.

Section 2

Employment Status: ○Full Time ○Part Time ○Retired

Student Status: ○Full Time ○Part Time

Medical ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

EFFECTIVE DATE: _____

FAMILY / SINGLE: _____

ASIAN: _____

HISPANIC: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

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

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○Self ○Spouse ○Child ○Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

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

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____