Port Arthur Smiles

www.PortArthurSmiles.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: ___________________