

CHESAPEAKE SMILES PATIENT REGISTRATION

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Female Male Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Social Security #: _____

E-mail: _____

I would like to receive email/text correspondences

Responsible Party: (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Female Male Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Social Security #: _____

Responsible Party is Policy Holder for Patient Primary Policy Holder Secondary Policy Holder

Primary Insurance Information:

Name of Policy Holder: _____ Relationship to Insured: Self Spouse Child

Policy Holder Social Security # or ID #: _____ Policy Holder Birth Date: _____

Employer: _____ Insurance Company: _____

Secondary Insurance Information:

Name of Policy Holder: _____ Relationship to Insured: Self Spouse Child

Policy Holder Social Security # or ID #: _____ Policy Holder Birth Date: _____

Employer: _____ Insurance Company: _____

Signature of Patient, Parent or Guardian

Date