



BELLINGHAM BAY DENTAL
PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: Policy Holder Preferred Name:
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
Medicaid ID: Pref. Dentist:
Employer ID: Pref. Pharmacy:
Carrier ID: Pref. Hyg.
Section 3
Referred By:
Previous Dentist:
Emergency Contact:
Emergency Contact #:

Primary Insurance Information
Name of Insured: Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: Insured Birth Date:
Employer: Ins. Company:
Address: Address:
Address 2: Address 2:
City, State, Zip: City, State, Zip:
Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information
Name of Insured: Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: Insured Birth Date:
Employer: Ins. Company:
Address: Address:
Address 2: Address 2:
City, State, Zip: City, State, Zip:
Rem. Benefits: .00 Rem. Deduct: .00