GHINA C. MALIHA, D.M.D., F.I.C.O.I.

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 ────   ──── Section 3 ────

Employment Status: ○ Full Time   ○ Part Time   ○ Retired   Emerg Contact: _____
                                                                     Emerg #: _____
Student Status: ○ Full Time   ○ Part Time   Phys Name: _____
                                                                     Phys #: _____
Medicaid ID: _____   Pref. Dentist: _____   Primary Ins Group #: _____
Employer ID: _____   Pref. Pharmacy: _____   Secondary Group #: _____
Carrier ID: _____   Pref. Hyg.: _____

┌─ Primary Insurance Information ───┐

Name of Insured: _____   Relationship to Patient: ○ 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 Patient: ○ 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

PLEASE TURN OVER, READ AND SIGN