Dr. Beth Hendlin DDS

PATIENT REGISTRATION

First Name: ________________________________ Last Name: ___________________ Middle Initial: __________

Patient Information

Address: ___________________________________ Address 2: ____
City ____ State/Zip: ____
Home Phone: ________________ Cellular: _________________ Work Phone: _________________ Ext: _________
Sex: ☐ Male ☐ Female Birth Date: _______________________ SS#: ____________________
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separate ☐ Widowed
Email: ____ ☐ I would like to receive correspondence via e-mail.

Employment Status: ☐ Full time ☐ Part Time ☐ Retired
Student Status: ☐ Full Time ☐ Part Time
Preferred Pharmacy: ____

Responsible Party *(if someone other than the patient)*

Address: ___________________________________ Address 2: ____
City: ____ State/Zip: ________________________
Home Phone: ________________ Cellular: _________________ Work Phone: _________________ Ext: _________
Sex: ☐ Male ☐ Female Birth Date: ______________________________ Soc Sec: ___________________
☐ Primary Insurance Policy Holder for Patient ☐ Secondary Insurance Policy Holder for Patient

Primary Insurance Information

Name of Insured: _______________________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Soc. Sec: __________________________ Insured Date of Birth: _________________________________
Employer: _________________________________ Ins. Company: _______________________________________
Address: __________________________________ Address: ____
Address 2: ________________________________ Address 2: ____
City, State, and Zip: _________________________ City, State, and Zip: ___________________________________

Group Number: _____________________________ Primary *Member ID:* _________________________________

Secondary Insurance Information

Name of Insured: _______________________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Soc. Sec: __________________________ Insured Date of Birth: _________________________________
Employer: _________________________________ Ins. Company: _______________________________________
Address: __________________________________ Address: ____
Address 2: ________________________________ Address 2: ____
City, State, and Zip: _________________________ City, State, and Zip: ___________________________________

Group Number: _____________________________ Primary *Member ID:* _________________________________