W. Lester Harris, D.M.D.
Patient Registration

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

Patient is: ❍ Policy Holder Prefered 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_____ Cellular: _____

Birth Date: _____ Social Secuirty _____ Drivers Lic: _____

Respnsible Party is also a ❍ Policy Holder for Patient ❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

PATIENT INFORMATION

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

Address: _____ Address 2: _____

City, State, Zip: _____ Email:_____

Home Phone _____ Work_____ Cellular: _____

Birth Date: _____ Social Secuirty _____ Drivers Lic: _____

Sex: ❍ Maile ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

❍ I would like to receive correspondeces via email.

SECTION 2

Employment Status: ❍ Full Time ❍ Part Time ❍ Retired

Student Status: ❍ Full Time ❍ Part Time

Medicaid ID: _____

Employer ID: _____

Carrier ID: _____

SECTION 3

test:

Pref. Dentist: _____

Pref. Pharmacy: _____

Pref. Hygienist:_____

PRIMARY INSURANCE INFORMATION

Name of Insured:_____ Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security:_____ Insured Birth Date:_____

Employer _____ Insurance Company_____

Address _____ Address _____

Addresss 2_____ Address 2_____

City, St., Zip _____ City, St., Zip _____

Rem. Benefits:_____ .00 Rem. Deduct: _____ .00

SECONDARY INSURANCE INFORMATION

Name of Insured:_____ Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security:_____ Insured Birth Date:_____

Employer _____ Insurance Company_____

Address _____ Address _____

Addresss 2_____ Address 2_____

City, St., Zip _____ City, St., Zip _____

Rem. Benefits:_____ .00 Rem. Deduct: _____ .00