



- Anderson Creek Dental Center
- Anderson Creek Medical Center
- Angier Medical Center

- Benhaven Medical Center
- Boone Trail Medical Center
- Mobile Unit (Dental / Medical)

PATIENT DATA FORM

Patient # _____ (PLEASE PRINT) Date: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Date of Birth: _____ Sex: (circle) Male Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Address: (if different from mailing address): _____

Home Phone or Contact Number: (____) _____ Work Phone Number: (____) _____

Employer: _____ Emp. Address: _____

Emergency Contact: _____ Relationship: _____ Phone Number: (____) _____

INSURANCE INFORMATION: Please check all that apply and have all cards available for copying.

Private Insurance _____ Medicare _____ Medicaid _____ Sliding Fee _____ Self Pay _____

Primary Insurance Number _____ Group Number _____

Secondary Insurance Number _____ Group Number _____

Guarantor (if applicable): _____ Relationship _____

DEMOGRAPHIC INFORMATION: Please circle all that apply.

Marital Status: (circle) Single Married Widow(er) Divorced Student: (circle) Full Time Part Time Not a Student

Employed: (circle) Full Time Part Time Unemployed Self Employed Retired Active Military

Do you live with: (circle) Both Parents Spouse Mother Only Father Only Homeless Other

Race: (Circle one race which you think best describes you)
 Other Pacific Islander Black/African American Asian Caucasian Native Hawaiian Other

Ethnicity (Hispanic or Latino): Yes No Veteran: Yes No Migrant: Yes No

Translation Services Needed: Yes No Language: _____

Household Income: \$ _____ per (circle): hour week bi-weekly monthly annual

Number of people in your household: _____ County of Residence: _____

CERTIFICATION I certify that the information given on this registration form is correct to the best of my knowledge.

Signature: _____ Relationship: _____ Date: _____

Patient, Guardian, and/or Financial Guarantor

If a patient is a minor or an incompetent adult, signature must be (1) Spouse (2) Guardian (3) Parent or known representative. Please show relationship.

Signature below acknowledges that you have received the HIPAA Notice of our Privacy Practices.

Signature: _____ Date: _____