

# JW SHADDIX, DDS

1204 Thomasville Court  
GARLAND, TX 75044  
214-213-4232

## PATIENT REGISTRATION

Patient 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: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc Sec: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers License Number: \_\_\_\_\_

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: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Drivers License Number: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondence via e-mail.

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

### Section 2

Employment Status:

Full Time  Part Time  Retired

Student Status:

Full Time  Part Time

### Section 3

Physician's Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Contact Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Social Sec: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Social Sec: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_