

**Harwell Palmer, DDS  
617 S Long Drive  
Rockingham, NC 28379**

**PATIENT REGISTRATION**

DATE\_\_\_\_\_

PREFERRED NAME\_\_\_\_\_

NAME (First)\_\_\_\_\_ (M)\_\_\_\_\_ (Last)\_\_\_\_\_

MAILING ADDRESS\_\_\_\_\_ CITY\_\_\_\_\_ STATE\_\_\_\_\_ ZIP\_\_\_\_\_

SOCIAL SECURITY #\_\_\_\_\_ EMAIL\_\_\_\_\_

SEX: M F      MARITAL STATUS: S M D W      DOB\_\_\_\_\_ AGE\_\_\_\_\_

HOME # (    )\_\_\_\_\_ CELL # (    )\_\_\_\_\_

EMPLOYER\_\_\_\_\_ WORK # (    )\_\_\_\_\_

EMERGENCY CONTACT\_\_\_\_\_ PHONE# (    )\_\_\_\_\_

IS PATIENT A STUDENT: Y N    IF SO SCHOOL: \_\_\_\_\_

**RESPONSIBLE PARTY**

NAME (First)\_\_\_\_\_ (LAST)\_\_\_\_\_

RELATIONSHIP TO PATIENT\_\_\_\_\_ DOB\_\_\_\_\_

SOCIAL SECURITY #\_\_\_\_\_ MARITAL STATUS: S M D W

HOME # (    )\_\_\_\_\_ CELL # (    )\_\_\_\_\_ WORK# (    )\_\_\_\_\_

EMPLOYER\_\_\_\_\_

**INSURANCE**

INSURANCE COMPANY\_\_\_\_\_ GROUP#\_\_\_\_\_

SUBSCRIBER OR MEMBER ID #\_\_\_\_\_

RELATIONSHIP TO PATIENT\_\_\_\_\_

INSURED EMPLOYER\_\_\_\_\_ EMPLOYERS PHONE # (    )\_\_\_\_\_

SUBSCRIBER SOCIAL SECURITY #\_\_\_\_\_

SUBSCRIBER DOB\_\_\_\_\_