



PATIENT REGISTRATION FORM – DENTAL CLINICS

(Please Print Clearly)

PATIENT INFORMATION

Last name:		First:		Middle:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> T
Birth date: / /	Social Security Number: - -	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Communication preference for appointment reminders (may select mult): <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> E-mail (provide e-mail address below) E-Mail:		
Street address:			Apt/Unit:	Home phone: ()	<input type="checkbox"/> Primary
City:		State:	ZIP Code:	Work phone: ()	<input type="checkbox"/> Primary
Employer:		City:	State:	Mobile phone: ()	<input type="checkbox"/> Primary
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline	Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Decline		Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No Language:	
Emergency Contact	Last Name:	First:	Phone: ()		
Relation to Patient: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other					

PERSON RESPONSIBLE FOR THE BILL (ONLY IF DIFFERENT FROM PATIENT)

<input type="checkbox"/> This person is a patient here	Last Name:	First:	MI:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> T
Street address:		Apt/Unit:	Phone: ()	
City:		State:	ZIP Code:	Relation to Patient: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other
Birth date: / /	Social Security Number: - -	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Employer Name: City: State:	

INSURANCE INFORMATION (A copy of your insurance card is required)

Is this patient covered by a Minnesota Health Care Program? <input type="checkbox"/> Yes <input type="checkbox"/> No (continue below)	ID#	Group # (if applicable)
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Commercial Insurance:

Policy Holder: Last name: <input type="checkbox"/> Patient	First:	MI:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> T
Street address: <input type="checkbox"/> Same as Patient	Apt/Unit:	Phone: ()	
City:		State:	ZIP Code:
Relation to Patient: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other			
Birth date: / /	Social Security Number: - -	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Employer Name: City: State:
Insurance Name:		<input type="checkbox"/> Dental <input type="checkbox"/> Medical	Group Number:
Insurance Billing Address:		City:	State:
		Insurance Start Date: M / Y	

SECONDARY INSURANCE INFORMATION

Policy Holder: Last name: <input type="checkbox"/> Patient	First:	MI:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> T
Street address: <input type="checkbox"/> Same as Patient	Apt/Unit:	Phone: ()	
City:		State:	ZIP Code:
Relation to Patient: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other			
Birth date: / /	Social Security Number: - -	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Employer Name: City: State:
Insurance Name:		<input type="checkbox"/> Dental <input type="checkbox"/> Medical	Group Number:
Insurance Billing Address:		City:	State:
		Insurance Start Date: M / Y	