Bring to your appointment
DO NOT MAIL.

PATIENT REGISTRATION FORM – DENTAL CLINICS

(Please Print Clearly)

PATIENT INFORMATION

Last name:	First:	Middle:	Sex: ❑ F ❑ M ❑ T

Birth date: / /	Social Security Number: - -	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	Communication preference for appointment reminders (may select mult): ❑ Phone ❑Text ❑E-mail (provide e-mail address below) E-Mail:

Street address:		Apt/Unit:	Home phone: ( ) ❑Primary
City:	State:	ZIP Code:	Work phone: ( ) ❑Primary
Employer: City:	State:		Mobile phone: ( ) ❑Primary

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline	Race: ❑ Asian ❑ Black or African American ❑ White ❑ American Indian or Alaska Native ❑ Native Hawaiian or other Pacific Islander ❑ Decline	Interpreter Needed? ❑ Yes ❑ No Language:

Emergency Contact	Last Name:	First:	Phone: ( )

Relation to Patient: ❑ Spouse/Partner ❑ Child ❑ Parent ❑Sibling ❑ Grandparent ❑ Legal Guardian ❑ Other

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

❑ This person is a patient here	Last Name:	First:	MI:	Sex: ❑ F ❑ M ❑ T

Street address:		Apt/Unit:	Phone: ( )
City:	State:	ZIP Code:	Relation to Patient: ❑Spouse/Partner ❑Child ❑Parent ❑Sibling ❑Grandparent ❑Legal Guardian ❑Other

Birth date: / /	Social Security Number: - -	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ 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?	❑ Yes ❑ No (continue below)	ID#	Group # (if applicable)

Commercial Insurance:

Policy Holder: Last name: ❑ Patient	First:	MI:	Sex: ❑ F ❑ M ❑ T

Street address: ❑ Same as Patient		Apt/Unit:	Phone: ( )
City:	State:	ZIP Code:	Relation to Patient: ❑Spouse/Partner ❑Child ❑Parent ❑Sibling ❑Grandparent ❑Legal Guardian ❑Other

Birth date: / /	Social Security Number: - -	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	Employer Name: City: State:

Insurance Name:	❑ Dental ❑ Medical	Group Number:	Policy Holder/ Subscriber ID:

Insurance Billing Address:	City:	State:	Insurance Start Date: /

SECONDARY INSURANCE INFORMATION

Policy Holder: Last name: ❑ Patient	First:	MI:	Sex: ❑ F ❑ M ❑ T

Street address: ❑ Same as Patient		Apt/Unit:	Phone: ( )
City:	State:	ZIP Code:	Relation to Patient: ❑Spouse/Partner ❑Child ❑Parent ❑Sibling ❑Grandparent ❑Legal Guardian ❑Other

Birth date: / /	Social Security Number: - -	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	Employer Name: City: State:

Insurance Name:	❑ Dental ❑ Medical	Group Number:	Policy Holder/ Subscriber ID:

Insurance Billing Address:	City:	State:	Insurance Start Date: /