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 ❑ Mixed Race ❑Decline	Interpreter Needed? ❑ Yes ❑ No If Yes, Language needed:

Emergency Contact	Last Name:	First Name:	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:	Middle:	Sex: ❑ F ❑ M ❑ T

Street address:	Apt/Unit:	Home phone: ( )
City: State: ZIP Code:		Alternate phone: ( )

Birth date: / /	Social Security Number: - -	Relation to Patient: ❑ Spouse/Partner ❑ Parent ❑ Grandparent ❑ Child ❑ Legal Guardian ❑ Sibling	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	ID#	Group #	

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

Street address: ❑ Same as Patient	Apt/Unit:	Home phone: ( )
City: State: ZIP Code:		Alternate phone: ( )

Birth date: / /	Social Security Number: - -	Relation to Patient: ❑ Spouse/Partner ❑ Parent ❑ Grandparent ❑ Child ❑ Legal Guardian ❑ Sibling	Employer Name: City: State:

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

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

SECONDARY INSURANCE INFORMATION

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

Street address: ❑ Same as Patient	Apt/Unit:	Home phone: ( )
City: State: ZIP Code:		Alternate phone: ( )

Birth date: / /	Social Security Number: - -	Relation to Patient: ❑ Spouse/Partner ❑ Parent ❑ Grandparent ❑ Child ❑ Legal Guardian ❑ Sibling	Employer Name: City: State:

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

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