Patient label
Please complete forms & return at appointment

REGISTRATION FORM – DENTAL CLINICS

PATIENT INFORMATION

06/03/2011

MALE ☐ **FEMALE** ☐

Name: _____ _____ _____
Last First Middle Initial

Address _____ _____ _____ _____ _____
Street Apartment Number City State Zip Code

Phone: (_____)_____ (_____)_____ (_____)_____
Home Work Cell

☐ **Address does not match** **Birth date:** _____ **SSN:** _____ - _____ - _____

Employer Name: _____

Emergency Contact Information _____
Last First
(_____)_____ _____
Phone Relationship

Single ☐ **Common-Law** ☐
Married ☐ **Separated** ☐
Divorced ☐ **Widowed** ☐

RESPONSIBLE PARTY and BILLING ADDRESS

Please complete if patient is under 18

Name: _____ _____ _____ _____ **Gender: M** ☐ **F** ☐
Last First Middle Inital Date of Birth

Address _____ _____ _____ _____ _____
Street Apartment Number City State Zip Code

Phone: (_____)_____ (_____)_____ (_____)_____
Home Work Cell

Relationship to Patient: _____ **Employer**: _____ **SSN**: _____

❖ **INSURANCE** Dental ☐ Medical ☐

Are you a college student? Full time ☐ **Part-time** ☐ **A copy of your insurance card is required.**

Insurance Name: _____ **Employer Name:** _____

Insurance Address: _____ **Ins Phone:** _____

Policy Holder: _____ _____ **Birth Date:** _____ **Gender: M** ☐ **F** ☐
(If different from patient) First Last

Address: _____ _____ _____ _____ _____
(If different from patient) Street Apartment Number City State Zip Code

Patient Relationship to Insured: Self ☐ **Spouse** ☐ **Dependent** ☐ **Other** ☐ **Policy Holder SSN:** _____

Group Number: _____ **Policy Holder/Subscriber ID:** _____

2nd Insurance Name: _____ Dental ☐ Medical ☐ **Employer Name:** _____

Insurance Address _____ **Ins Phone:** _____

Policy Holder: _____ _____ **Birth Date:** _____ **Gender: M** ☐ **F** ☐
(If different from patient) Last First

Patient Relationship to Insured: Self ☐ **Spouse** ☐ **Dependent** ☐ **Other** ☐ **Policy Holder SSN:** _____

Group Number : _____ **Subscriber ID:** _____

❖ **MINNESOTA HEALTH CARE PROGRAMS**

Please check one: **Medical Assistance** ☐ **Minnesota Care** ☐ **General Assistance** ☐

ID# _____ **Group Number:** _____

Medica **UCare**
Blue Plus **HealthPartners**
MHP **FirstPlanBlue**
Non-Managed Care FFS MA