

PATIENT REGISTRATION FORM — DENTAL CLINICS (Please Print Clearly)

			PA	TIENT	INFO	RM	ATION								
Last name:	st name:		First:						Middle:			ex: F	п м	пΤ	
Birth date:	Social Security Number:		Marital Status: ☐ Single ☐ Mar			rried Phone T			oreference for appointment reminde ext □E-mail (provide e-mail ac					mult):	
/ /		☐ Divorced ☐ Separated ☐ E-Mail:													
Street address:					Apt/Unit:			Home phone:				□Primary			
City:			State:			ZIP Code:			Work phone:				□Primary		
Employer:			Cit	y & State				Mobile phone:				□Primary			
Ethnicity: Hispanic or Not Hispan	Asian African Ar	n										□ No			
Emergency Contact Last Name:				First Nam	ie:			Phone:							
Relation to Patient:	d □ Pa	rent	□Sibling	□ G	Frand	parent 🗖 Le	gal Gua	rdian 🗖 O	ther						
	PERSON RESPONSIBLE FOR THE BILL (ONLY IF DIFFERENT FROM PATIENT)														
☐ This person				First:					Middle:			ex:	п м	ΩТ	
Street address:					Apt/Unit:			Home phone:							
City:			State:			ZIP Code:			Alternate phone:						
Birth date:			Patient:	□ Par	□ Parent Employer Nar										
/ /		□ Spouse/Partner □ Parent □ Child □ City: □ Legal Guardian □ Sibling							State:						
			INSU	RANC	E INF	OR	MATION	(A cc	opy of your	r insurar	nce card	d is re	equire	ed)	
Is this patient covered b Minnesota Health Care		ID#		RANC	E INF	FOR	MATION	(A co		r insurar	nce card	d is re	equire	ed)	
	Program?			First:	E INF	OR	MATION	•			S	ex:	equire		
Minnesota Health Care Policy Holder: Last nar	Program?					Apt/L		Group) #		S	ex:			
Minnesota Health Care Policy Holder: Last nar Patient is Policy Hold Street address:	Program?		E			Apt/L		Group Home	Midden phone:		S	ex:			
Minnesota Health Care Policy Holder: Last nar Patient is Policy Hold Street address: Same as Patient City: Birth date:	Program?	Sta	te: ation to	First: Patient: Partner	ZIP (Apt/L	Jnit: Employer Na	Home (Altern	Midd		S	ex: F			
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