Affix Patient Label Here

REGISTRATION FORM – DENTAL CLINICS

PATIENT INFORMATION

MALE ☐ **FEMALE** ☐

Name: ____________________ ______ ____________________
First Middle Initial Last

Address____________________ __________ __________ ______ ______
Street Apartment Number City State Zip Code

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

Birth date: __________ **SSN:** __________ **County:** __________

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

Patient Marital Status **Single** ☐ **Married** ☐ **Other** ☐

RESPONSIBLE PARTY and BILLING ADDRESS

Complete only if patient is under 18 or is not responsible for payment.

SEND BILLS TO: Patient ☐ **Responsible Party** ☐

Name: __________ ___ __________ __________ **Gender: M**☐ **F**☐
First MI Last 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:** __________

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

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

Insurance Address ____________________ **Ins Phone:** __________

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

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

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

❖ 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