

LABEL



REGISTRATION FORM – DENTAL CLINICS

PATIENT INFORMATION

Name: _____ MALE FEMALE
Address _____
Phone: (_____) _____ (_____) _____ (_____) _____
Birth date: _____ SSN: _____ County: _____
Emergency Contact Information _____ Patient Single
Marital Status 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
Address _____
Phone: (_____) _____ (_____) _____ (_____) _____
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
Address _____
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
Address _____
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: _____