REGISTRATION FORM – DENTAL CLINICS

Date:

PATIENT INFORMATION

Name: _____ **M** ☐ **F** ☐

Address : _____
Street Apartment Number City State Zip Code

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

Birth date: _____ **SSN:** _____ **County:** _____

Emergency Contact Info _____ _____ (_____)_____ _____
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 Suffix (Jr, Sr, II, etc.)

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

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

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

❖ DENTAL INSURANCE

Do you have dental insurance? No ☐ **Yes** ☐ **If yes, please continue-**

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: _____**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** ☐

Plan→ Medica ☐ **UCare** ☐ **MHP** ☐ **BluePlus** ☐ **HealthPartners** ☐ **DHS** ☐ **SCHA** ☐ **Other** ☐_____

ID# _____ **Group Number:** _____

Office Use Only: J F M A M J J A S O N D Year

Patient Name:

University of Minnesota
School of Dentistry Clinics

Consent for treatment: I hereby authorize the faculty of the School of Dentistry (School) and the students and staff working under their supervision, to perform ordinary diagnostic procedures, including x-rays and photographs, to determine the general nature of my dental problems. I understand that the benefits, alternatives, discomforts and risk relating to my dental treatment will be explained to me in terms that I understand and properly annotated in my chart using appropriate consent forms before treatment is initiated. My special consent will be obtained for procedures such as general anesthesia, sedation or procedures with potential complications as determined by the attending dental specialist.

Consent for photos: I consent to be interviewed/photographed/audiotaped/videotaped for the purpose of education and medical instruction as the University of Minnesota's School of Dentistry deems appropriate.
I further consent that such Information/photography/audiotape/videotape shall be the exclusive property of the Regents of the University of Minnesota, free and clear of any claim on my part.

Consent for Assignment of Insurance benefits: I authorize the payment of insurance benefits otherwise payable to me directly to the School. The School may share my medical and financial information with Medicare, other government payers, and accident or health insurers for the purpose of payment, claims processing, fraud investigations or quality of care reviews. When benefits are not paid to the School amounts owing are due immediately.

Collection costs: I agree to reimburse the School for the costs and expenses incurred by the School in connection with the collection of amount(s) due hereunder, including reasonable attorneys' fees and related costs.

Payment: I understand as a patient or as the responsible party that I agree to pay for services provided. Down payments are required for services incurring laboratory expenses. Payment options in the graduate orthodontic program will be discussed when you meet with the Orthodontic Clinic financial coordinator.

Patient Brochure and Patient Bill of Rights: I agree that I have received a copy of the brochure entitled, "Patient Information Brochure and Patient Bill of Rights" that contains information about the following:

- My rights and responsibilities as a patient
- Payment for services
- Fee estimates
- Treatment policies and appointments
- Cancelling appointments and fail policy
- How to contact us 612-625-6444

University of Minnesota Acknowledgement of Notice of Privacy Practices Form: I have received the University of Minnesota HIPAA Notice of Privacy Practices.

I HAVE CROSSED OUT AND INITIALED STATEMENTS TO WHICH I DO NOT CONSENT OR AGREE.

(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY)	LEGAL RELATIONSHIP	DATE