WOODLAND DENTAL, INC.
Website: http://www.woodlanddental.org

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Wadena, MN 56482
(218) 631-4431

NEW PATIENT REGISTRATION

****Reason for visit? (Please circle all that apply)** **Have you been told you snore? Yes No**

Routine Dental Care Dentures Partials Implants Tooth Ache Sleep Apnea Other

Responsible Party Information (Please fill out if other than patient)

First Name: ____________________________ Last Name: ___________________ MI: _____

Address: _________________________________ Maiden Name:______________________

City: ______________________________ State/Zip: ____________

Home phone: ___________________ Cell phone: _______________ Work Phone:_____________

Date of Birth for Responsible Party: ___________ Email: __________________________________

Are you the responsible party:

☐ The Policy Holder for the Patient ☐ The Primary Policy Holder ☐ Secondary Policy Holder

Patient Information

First Name: ____________________________ Last Name: ___________________ MI: _____

Address: _________________________________

City: ______________________________ State/Zip: ____________

Home phone: ___________________ Cell phone: _______________ Work Phone:_____________

Date of Birth of Patient: ______________

Gender: ☐ Male ☐ Female ☐ Married ☐ Single

Race: ☐ White (Caucasian) ☐ Native American ☐ Asian ☐ Black or African American

Other Race: ___________________________ Preferred Language: _________________________

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Policy 1/ Primary Insurance Info

Name of Insured: ____________________________

Address: ___________________________________

City: ______________________Zip: ____________

Policy Holder ID # ____________________________

Employer: __________________ DOB: __________

Relationship to Insured: ☐ self ☐ spouse ☐ child ☐ other

Insurance Company: __________________________

Send Claims to Address: ______________________

City, State, Zip _______________________________

Policy 2/ Secondary Insurance Info

Name of Insured: ____________________________

Address: ___________________________________

City: ______________________Zip: ____________

Policy Holder ID # ____________________________

Employer: __________________ DOB: __________

Relationship to Insured: ☐ self ☐ spouse ☐ child ☐ other

Insurance Company: __________________________

Send Claims to Address: ______________________

City, State, Zip _______________________________