UCSF Benioff Children's Hospital San Francisco

UCSF Pediatric Dentistry at Mission Bay
Patient Registration Form

Date: ___/____/____

Patient's Name_____ Date of Birth____/____/___

Street Address _____ Apt #_____

City _____ State_____ Zip Code_____

Home phone (____) _____ Work phone (____) _____

Cell phone (____) _____ Other phone (____) _____

Email Address: _____

Gender (circle) Male Female

Does the patient have Denti-Cal? No___Yes___ B.I.D. #_____

Where did you hear about UCSF Dental Clinics? _____

Please select your racial background:

___Asian
___African American/Black
___American Indian
___Alaskan Native
____Pacific Islander
____White
____Other
____Unknown

Please select your ethnicity:

___Hispanic Origin
___Non-Hispanic Origin
____Unknown

In order to IMPROVE our oral health services for you-our patients-please indicate your preferred language.

Preferred Language:

___Arabic	___Cantonese	___Chinese	___Danish	___Dutch	___English
___Farsi	___Finnish	___French	___German	___Greek	___Icelandic
___Italian	___Japanese	___Korean	___Mandarin	___Norwegian	___Portugese
___Russian	___Sign Lang	___Spanish	___Swahili	___Swedish	___Vietnamese

Emergency Contact Information

Name of significant other/closest relative:_____ Relationship: _____
Home Phone: ( )_____ Cell Phone: ( )_____
Work Phone: ( )_____ Contact E-mail:_____

Financial Responsible Party

First Name:_____ Middle:_____ Last Name:_____ Relationship to Patient:_____
Home Phone: ( ) _____ Cell Phone: ( )_____ Work Phone: ( )_____
Street Address: _____ City: _____ Social Security# _____
State: ____ Zip: _____Contact E-mail: _____DOB:_____

Does the patient have DENTAL insurance coverage? (circle) Yes or No

If yes, please fill out the information below

Policy Holder's Name:_____

Policy Holder's Employer:_____

Policy Holder's Insurance ID# :_____

Policy Holder's Gender (circle): Male Female

Policy Holder's Date of Birth: _____

Policy Holder's Relationship to Patient: _____

Name of Insurance Company:_____

Mailing Address:_____ Phone Number ( )_____
Group#:_____ Policy #:_____

Does the patient have a second DENTAL insurance coverage? (circle) Yes or No

If yes, please fill out the information below

Policy Holder's Name:_____

Policy Holder's Employer:_____

Policy Holder's Insurance ID# :_____

Policy Holder's Gender (circle): Male Female

Policy Holder's Date of Birth: _____

Policy Holder's Relationship to Patient: _____

Name of Insurance Company:_____

Mailing Address:_____ Phone Number ( )_____
Group#:_____ Policy #:_____

Signature of Parent/Legal Guardian: _____ Date: ___/____/____

FINANCIAL INFORMATION: UCSF Pediatric Dentistry will help you with billing your insurance carrier according to the information provided above. However, please remember that you are ultimately responsible for payment of all charges unless we are a contracted provider for you dental coverage. Our staff is happy to answer any questions you may have.