

PATIENT INFORMATION (CONFIDENTIAL)

DATE _____

NAME _____ BIRTHDATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CONTACT NUMBERS:

HOME PHONE: _____ CELL PHONE: _____ BUSINESS: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PHONE# _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

(IF DIFFERENT FROM ABOVE)

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

ELIGIBILITY

RETIRED: YES If yes, are you a retired teamster- Wisconsin Health Fund Member Yes No
 NO If no, please list insurance information below

INSURANCE INFORMATION

WHF PLAN

PREMIER A1 A2 B

PRIMARY INSURANCE - (IF OTHER THAN WHF, PLEASE COMPLETE ALL INFORMATION)

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ PHONE _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ PHONE _____ GROUP# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE - (IF OTHER THAN WHF, PLEASE COMPLETE ALL INFORMATION)

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ PHONE _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ PHONE _____ GROUP# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

REGISTRATION

WHF

Wisconsin Health Fund Dental Center 6200 W. Bluemound Road, Milwaukee, WI 53213 Phone 414-771-5600

D004 Patient Registration