

HealthPartners Patient Information Update

[patient.firstname] [patient.lastname]
[household.address1]
[household.address3], [household.state] [household

Changes to address or telephone?

Chart#: [patient.code]
DATE OF BIRTH: [patient.dob]
H-PHONE: [patient.homephone]
W-PHONE: [patient.workphone]

Email: _____ *Enter only if you agree to allow HealthPartners to contact you via email.*

Should address apply to all members on this account? Y_____ N_____

Name of person to contact in case of emergency

Phone #: _____ Name: _____

Your HealthPartners Dental clinic needs to be kept informed of the correct name, address and account number of your non-HealthPartners insurance carriers. If the information is not current and correct, your claims will not be processed correctly and timely.

Do you have a health insurance carrier other than HealthPartners that covers your Dental care? Y_____ N_____ Medical care? Y_____ N_____

If yes complete insurance information below:

Name of Dental Insurance Company: _____ Ph.#: _____
Address of Insurance Company: _____

Policy Holder of Contract: _____ SS#: _____
Name of Employer: _____ Group #: _____
Effective Date of Policy: _____
Family Coverage? Y_____ N_____ Birthdate of Policy Holder _____

Name of Medical Insurance Company: _____ Ph.#: _____
Address of Insurance Company: _____

Policy Holder of Contract: _____ SS#: _____
Name of Employer: _____ Group #: _____
Effective Date of Policy: _____
Family Coverage? Y_____ N_____ Birthdate of Policy Holder _____

Fee for Service Guarantor Information: (Person to be billed for non-covered or Fee for Service charges)

Name: _____ Date of Birth: _____
Address: Steet: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ SS#: _____