UNIVERSITY OF KENTUCKY
COLLEGE OF DENTISTRY

(office use only)
Chart # ________________________

PATIENT REGISTRATION/AUTHORIZATION AND CONSENT FORM

Today's Date:___________________

Have you ever received treatment from any UK Dental Clinic before today? ☐ Yes ☐ No

Patient Social Security Number:_________________ Date of Birth:____________ Sex: ☐M ☐F

Patient Last Name First Name M.I. Maiden Name *(if applicable)*

_________________________ ______________________ ____ _________________________

Street Address City County State Zip Code

___________________________ ___________________ ___________ _____ ____________

Phone: Home: (____)_____________________ Work: (____)____________________________
Cell: (____)______________________ Other: (____)____________________________
E-mail Address:____

Employer/Employer's Address:____

Do you have: (C*heck all that apply and provide card to staff at desk.*)
☐ No Insurance
☐ Medicaid
☐ Medical Insurance
☐ Other *(example: Commission, Agency, Auto)*_______________________
☐ UK Dental Care: *plan type*______________
☐ Other Dental Insurance
☐ Medicare

Policy Holder Name:__________________________ Group/Plan Number:___________________

SSN: ___________________________ Date of Birth: ________________________

Emergency Contact

Name Home Phone Work Phone Cell (Other)

______________________ (____)______________ (____)_____________ (___)______________

Address Relationship to Patient

____ __________________________________

Responsible Party (*Person responsible for payment*) Social Security Number:_________________
If same as above, please check here: ☐
Relationship to Patient: ☐ Spouse ☐ Parent/Guardian of Minor ☐ Other__________________
Last Name First Name M.I. Maiden Name *(if applicable)*

________________________ _______________________ ___ ___________________________

Street Address City State Zip Code

_____________________________ ____________________ ______ ___________________

Phone: Home: (____)____________________ Work: (____)____________________________
Cell: (____)______________________ Other: (____)____________________________
Email Address: ____

Employer/Employer's Address:____

SEE OTHER SIDE

(office use only)

Patient Name: ____________________________ **Account #:** _________________

Consent to Treatment

I authorize the rendering of treatment, services and procedures, by authorized agents and employees of the University of Kentucky College of Dentistry, or their designees, as may in their professional judgment be deemed necessary or beneficial, including laboratory testing. I understand that all diagnostic aids (including images) are the property of the University of Kentucky and that my records may be used for research (including publication) purposes, to evaluate the skills, qualifications and performance of our providers and to provide training programs for students.

Release of Information

I authorize the release of information from the above-named patient's records to any payor, including insurance companies or government agencies, as required by such payor for payment, peer review, or quality assurance purposes.

Payment Guarantee

I agree to be responsible for payment in full of charges resulting from treatment or services rendered. Should I fail to make payment in full, I agree to pay any additional collection costs or attorney fees associated with collection of my account. No granting of extensions or delays in collection efforts shall constitute a forgiveness of amounts due. I agree the College of Dentistry is not a party to any disputed claim or peer review decision which affects payment of claim filed upon my behalf and upon request for payment I agree to pay any outstanding balance. Further, I understand that I may be contacted regarding payment using any information provided elsewhere within my record.

Assignment of Benefits

I hereby assign all rights and authorize payment directly to the College of Dentistry for any claim filed on the above-named patient's behalf. I understand that I am financially responsible to the College of Dentistry for charges not covered by an assignment of benefits or paid on a timely basis by an insurance company.

I certify that I have read and agree with the above statements, agreements and authorizations. Further, I certify that all information provided is true and accurate.

______________________________ ________________________________ _________

Patient Signature *Responsible Party, if different* *Date*