UNIVERSITY OF MICHIGAN SCHOOL OF DENTISTRY
Registration and Treatment Consent Form

Patient Registration Information – Please Print

Title	Patient's Last Name	First Name	Middle	Preferred	Gender

Date of Birth	Social Security No.	Marital Status	College Student?	Name of School, City, State

Home Address	Apt or Box No.	City	State	Zip Code	Email Address

Home Phone No.	Daytime Phone No.	Secondary No.	Preferred Contact No.

Emergency Contact – Name	Relation	Daytime Phone No.	Address (Street, City, State, Zip)

Guarantor/Guardian Information

Title	Last Name	First Name	Middle	Relation	Gender

Date of Birth	Social Security No.	Marital Status		

Home Address	Apt or Box No.	City	State	Zip Code	Email Address

Home Phone No.	Daytime Phone No.	Secondary No.	Preferred Contact No.

Patient's Primary Dental Insurance Information

Subscriber's Name	Subscriber's ID	Subscriber's DOB	Insurance Co.	Group No.

Employer	Address of Employer	Subscriber's Relationship to Patient

Patient's Secondary Dental Insurance Information

Subscriber's Name	Subscriber's ID	Subscriber's DOB	Insurance Co.	Group No.

Employer	Address of Employer	Subscriber's Relationship to Patient

Assignment of Benefits and Release of Information

I authorize the University of Michigan School of Dentistry (UMSD) or the Dental Faculty Associates (DFA) to release any and all information contained in my dental/medical records to (a) any third party payer, insurance agencies or carriers or their agents which may be responsible in whole or in part for paying any expenses associated with my treatment; (b) any health care facility or provider for the purpose of facilitation continuing care and treatment; (c) attorneys or agencies representing the UMSD or the DFA in connection with collection actions against insurers, benefit plan, or the patient, or estate; and (d) any federal or state agency as required by law.

I assign and authorize direct payment of all health care benefits and other forms of payment of any kind which relate to the care provided to me at the UMSD, the DFA or its offsite clinics for application to my bill(s). I assign to the UMSD or the DFA all claims benefits or any related rights or claims I may have under the Employment Retirement Income Security Act (ERISA) or other applicable law, against any insurer, employee, trustee, fiduciary, employee welfare plan, employee benefit association, or other person who may be liable to pay charges due to the UMSD or the DFA for my care, and agree that the UMSD or the DFA may pursue any claim to these benefits, whether or not I choose to pursue that claim. I guarantee full financial responsibility for payment of all expenses associated with my care and treatment, including any portion of any charges not paid by insurance, including motor vehicle insurance, worker's compensation or social agencies and agree to pay the same at the time of delivery of service, discharge from treatment, or on any interim basis. These expenses will include but are not limited to deductibles, co-insurance, non-covered benefits services, and services requiring prior authorization which were not authorized

Signature of Patient, Parent, or Guardian _____ Date _____ Relationship to Patient _____

Treatment Information:

Welcome to the School of Dentistry. Before signing this treatment consent form, please read the following information. If you have questions regarding any of these conditions, please ask a staff member for help.

1. Patient care by students, under the supervision of faculty dentists, will proceed slower than in private dental practice.
2. Treatment expressly for relief of pain, or discomfort, does not commit the School of Dentistry to further treatment.
3. Patient records, x-ray, photographs and other diagnostic aids are the property of the School of Dentistry. Duplication of x-rays is available upon written request along with a processing fee.
4. Failure to keep appointments may result in the discontinuation of treatment.

Consent for Dental Treatment

I give consent for dental treatment for the patient named above to the faculty, students, and other health care providers at the School of Dentistry. I understand there are some risks inherent in all dental procedures, including the administration of local anesthesia and drugs common to dental practice. I understand I am free to ask any questions regarding proposed treatment and risks involved.

Signature of Patient, Parent, or Guardian _____ Date _____ Relationship to Patient _____

Witness Signature _____ Date _____