SCHOOL OF DENTISTRY
UNIVERSITY OF MICHIGAN

Patient Registration Information – Please Print using black or blue ink

Title	Patient's Last Name	First Name	Middle	Preferred	Gender

Date of Birth	Social Security No.	Marital Status	Email Address

Home Address	Apt or Box No.	City	State	Zip Code

Home Phone Number _____ Daytime Phone Number _____ Cell Phone Number _____

Preferred Method of Contact:
Text me at ( ) _____ Send me an email at _____@_____ Call me at ( ) _____

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

Race/Ethnicity (optional)
Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐

Hispanic / Latin / Spanish Yes ☐ No ☐

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 Number Daytime Phone Number Cell Phone Number Preferred Contact Number

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**

_____ _____
Witness Signature Date

Revised 9/2019