UNIVERSITY OF OREGON

UHC DENTAL CLINIC
PATIENT REGISTRATION

First Name: Last Name: Middle Initial:

Preferred Name: Preferred Pronoun:
Gender: Female ☐ Male ☐ Transgender ☐ Not Specified ☐

PATIENT INFORMATION:
Local Address:
City, State, Zip:
Cell Phone:
Would you like to receive text correspondences? Yes ☐ No ☐
Birth date: Drivers Lic#:

E-mail: ☐ I would like to receive email correspondences

Student Status (check all that applies): Full Time ☐ Part Time ☐

GTFF ☐ Law Student ☐ International Student ☐ AEI ☐

********BRING DENTAL INSURANCE CARD TO YOUR APPOINTMENT*******

PRIMARY INSURANCE INFORMATION:

Name of Insured:
Relationship to Insured:
Group #:
Insured Birth date:
Insured Member ID:
Insurance Company:
Employer:
Claim Address:
Insured Address:
Insurance Phone #:
Insured's Phone #:

I hereby consent to the University of Oregon, including any of its school officials, releasing my educational records as stated below:

Specific records to be released: **Records relating to: (1) billing third parties for health care services provided to me; or (2) paying for health care services provided to me.**

Purpose for release: **To bill or to pay for healthcare services provided to me.**

Party or class of parties to whom the records are being released: **(1) Health care providers who have provided treatment to me; (2) insurance companies that are obligated to pay for health care services provided to me; and (3) other third parties that process payment for health care services provided to me**.

Printed Name: UO Student ID No:

Signature: Date: