

**UHC DENTAL CLINIC
PATIENT REGISTRATION**

First Name: Last Name: Middle Initial:
Preferred Name: Preferred Pronouns:
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
 Grad Student Law Student International Student

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

PRIMARY INSURANCE INFORMATION:

Name of Insured: Relationship to Insured:
Employer ID: Carrier ID:
Insured Member ID #: Insured Birth date:
Employer: Insurance Company:
Address: Address:
City, State, Zip: City, State, Zip:
Employer Phone #: Insurance 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: