For Office Use Only:

FACULTY CLINIC_____ DR._____ ACCT.#_____

DATE _____ CHART # _____ NO CHANGES ❑ UPDATE ONLY ❑

PATIENT REGISTRATION

Patient Name (Last) (First) (Middle)			❑ Male ❑ Female
Mailing Address Apt. #			Patient Date of Birth
City State Zip			Patient Status: ❑ Single ❑ Married ❑ Other
Occupation	Employer's Name	Home Phone ( )	Work Phone ( )
In Case of Emergency Notify Name:	Phone: ( ) Relationship:		Spouse Name

Referring Physician ❑ or Dentist ❑ Name:				Phone ( )
Address:	City	State	Zip	
Reason for Referral:				

II. MINOR PATIENT or GUARANTOR INFORMATION

(If patient is a minor or dependent, please complete this section.)

Mother's Name & Address	Soc. Sec. No.	Day Phone ( )	Eve Phone ( )	Guarantor ❑
Father's Name & Address	Soc. Sec. No.	Day Phone ( )	Eve Phone ( )	Guarantor ❑

III. SPECIAL CARE INFORMATION

DSHS Coverage Are you eligible for dental care coverage under Department of Social and Human Services (DSHS)? ❑ Yes ❑ No If yes, attach coupon in space provided	Race/Ethnicity What do you consider your race or ethnic background? (e.g. Caucasian, Hispanic/Latino, African American, Native American, Asian, etc.)
Medicare Coverage Are you eligible for Medicare? ❑ Yes ❑ No If yes, provide your Medicare # ----------	
Interpretive Services Interpretive services needed? ❑ Yes ❑ No If yes, type: ----------	
Labor & Industries Accident Cases Is your need for treatment associated with a Labor & Industries accident? ❑ Yes ❑ No If yes, provide the: 1. Accident Date: ---------- 2. L & I Case #: ----------	

(CONTINUED ON BACK)

IV. PRIMARY INSURANCE COVERAGE INFORMATION

Do you want the University of Washington to submit your insurance claim for your care? ❑ Yes ❑ No

If yes, complete the insurance information below and sign the assignment of benefits statement at the bottom of the page. All the information below is required in order for us to submit your claim.

Note: The "subscriber" is the person who carries the insurance for his/her dependents.			Patient's Relationship to the Subscriber: Self ❑ Spouse ❑ Dependent ❑ Other ❑ **Type of Insurance:** ❑ **Dental** ❑ **Medical**		
Subscriber Name			Subscriber Address		
City	State	ZIP	Subscriber Date of Birth	Subscriber Soc. Sec. #	Subscriber ID#
Insurance Company Name			Insurance Company Address		
City	State	ZIP	Insurance Phone # ( )	Insurance FAX # ( )	
Insurance Plan Name			Group Number	Employer Name	
Employer Address			City	State	ZIP

V. SECONDARY INSURANCE COVERAGE INFORMATION

Note: The "subscriber" is the person who carries the insurance for his/her dependents.			Patient's Relationship to the Subscriber: Self ❑ Spouse ❑ Dependent ❑ Other ❑ **Type of Insurance:** ❑ **Dental** ❑ **Medical**		
Subscriber Name			Subscriber Address		
City	State	ZIP	Subscriber Date of Birth	Subscriber Soc. Sec. #	Subscriber ID#
Insurance Company Name			Insurance Company Address		
City	State	ZIP	Insurance Phone # ( )	Insurance FAX # ( )	
Insurance Plan Name			Group Number	Employer Name	
Employer Address			City	State	ZIP

I authorize the University of Washington School of Dentistry, or my insurance company, to release any information required for payment or review of this claim. I am financially responsible to the School of Dentistry for all balances due, and assign my benefits to the School of Dentistry.

_____ _____

Patient/Guardian Signature Date