University of Pittsburgh

UNIVERSITY DENTAL HEALTH SERVICES INC.

PATIENT REGISTRATION FORM

UPMC Montefiore
Suite 202 South
3459 Fifth Avenue
Pittsburgh, PA 15213
412-648-6730
Fax: 412-648-6505

Main Office
Suite 3189 Salk Hall
3501 Terrace Street
Pittsburgh, PA 15261
412-648-9100
Fax: 412-383-9829

Oral Surgery
Suite G32
412-648-8604
Fax: 412-648-3600

Print

Primary Care Physician: _____ Phone: _____
(Full name)

Referring Doctor: _____ Phone: _____
(Full name)

Name: Last, First, MI _____ Date of Birth: _____ SS#: _____
Street Address: _____ Gender: M ☐ F ☐ Marital Status: _____
City: _____ State: _____ Zip: _____ **Please list each:**
Employer Name: _____ E-mail: _____
Street Address: _____ Home #: _____ Cell #: _____
City: _____ State: _____ Zip: _____ Work #: _____

SUBSCRIBER: DENTAL INSURANCE DATA Please present your insurance card(s)

Dental Insurance 1: Dental Company Name: _____
Dental Insurance 1: ID#: _____ Group #: _____
Subscriber Name: Last, First, MI _____ Date of Birth: _____ SS#: _____
Check Here If Address Is Same As Patient: ☐ Gender: M ☐ F ☐ Marital Status: _____
Street Address: _____ City, State, Zip _____
Relationship to Patient _____ E-mail: _____
Home #: _____ Work #: _____ Cell #: _____

Dental Insurance 2: Dental Company Name: _____
Dental Insurance 2: ID#: _____ Group #: _____
Subscriber Name: Last, First, MI _____ Date of Birth: _____ SS#: _____
Check Here If Address Is Same As Patient: ☐ Gender: M ☐ F ☐ Marital Status: _____
Street Address: _____ City, State, Zip _____
Relationship to Patient _____ E-mail: _____
Home #: _____ Work #: _____ Cell #: _____

SUBSCRIBER: MEDICAL INSURANCE DATA Please present your insurance card(s)

Medical Insurance 1: Medical Company Name: _____
Medical Insurance 1: ID#: _____ Group #: _____
Subscriber Name: Last, First, MI _____ Date of Birth: _____ SS#: _____
Check Here If Address Is Same As Patient: ☐ Gender: M ☐ F ☐ Marital Status: _____
Street Address: _____ City, State, Zip _____
Relationship to Patient _____ E-mail: _____
Home #: _____ Work #: _____ Cell #: _____

Medical Insurance 2: Medical Company Name: _____
Medical Insurance 2: ID#: _____ Group #: _____
Subscriber Name: Last, First, MI _____ Date of Birth: _____ SS#: _____
Check Here If Address Is Same As Patient: ☐ Gender: M ☐ F ☐ Marital Status: _____
Street Address: _____ City, State, Zip _____
Relationship to Patient _____ E-mail: _____
Home #: _____ Work #: _____ Cell #: _____

ACCIDENT INFORMATION—COMPLETE ONLY IF VISIT IS DUE TO AN ACCIDENT

Date of Accident: _____ [Attach Workers' Comp./Auto Insurance Co. Name, Address, and Phone #]
Type: ☐ Auto ☐ Work-related ☐ Other Claim #: _____

MINORS: PARENT/GUARDIAN INFORMATION OR EMERGENCY INFORMATION

Name: _____ Relationship to Patient: _____
Check Here If Address Is Same As Patient: ☐ Home #: _____
Address: _____ Work #: _____ Cell #: _____

RELEASE OF DENTAL/MEDICAL INFORMATION Please read and sign below

I request that payment of authorized Medicare/other insurance benefits be made on my behalf to UDHS for any services furnished me by dentist, physician, or supplier. I authorize the release of dental and/or medical information about me to the Centers for Medicine and Medicare and Medicaid Services and/or my insurance company and its agents—any information needed to determine these benefits/benefits payable for related services. I am responsible for all charges, regardless of insurance status, as well as copayments and deductibles.

Patient/Guardian Signature: _____ Date: _____

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