UAD UNIVERSITY ASSOCIATES IN DENTISTRY
Dental Implant Institute of Chicago

REGISTRATION FORM

Patient Information

Today's Date _____ Male____ Female____ Marital Status_____

Name _____ Date of Birth _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone #( )_____ Work Phone # ( )_____

Cell Phone/Pager ( )_____ E-mail Address _____

Social Security # _____

Person to contact in case of an emergency _____ #_____

Responsible Party

Name _____ Relationship to Patient _____

Address _____ City _____ St _____ Zip _____
(If different from above)

Home Phone #( )_____ Work Phone # ( )_____

Social Security # _____ DOB _____

Insurance Information

Employee Name _____ Employer Name _____

Insurance Company _____ Group Number _____

Insurance Company Phone Number _____Fax Number_____

Employee Date of Birth _____ Employee Social Security # _____

Referred By…

Whom may we thank for referring you to our office:

_____

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient's name) _____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have been given the opportunity to read and review the Federal (HIPAA – Health Insurance Portability and Accountability Act). Other than is stated by the act or where Federal State or Local law requires, my health information will not be disclosed without further written authorization. I may revoke this authorization in writing at any time. Initial _____

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsibly for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) and any expenses such as attorney fees, if engaged for the purpose of collections, may be added to my account.

Patient's or Responsible Party's Signature _____ Date _____