UB School of Dental Medicine

Patient Application (Please Print)

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Mr. Mrs. Miss Ms. Dr. Name_____
Last First Middle Initial

Date of Birth: _ _/_ _/_ _ M F Social Security Number _ _ _/_ _/_ _ _ _

Email address: _____

Race / Ethnicity: (circle one) Caucasian African American Asian Hispanic Other
Any special needs we should know about? Blind Deaf Wheelchair Other _____
Preferred language? _____

Have you ever been treated at the UB School of Dental Medicine in the past? Y N

Are you a UB student? Y N If yes, SUNY ID Number_____

Do you have a healthcare proxy? Y N
If so, who is your appointed agent? _____
Phone number of appointed agent: _____

Local Address: Permanent Address if different than local:

Street_____ Street_____

Apt. _____ Apt_____

City _____ City_____

State / Province_____ State / Province_____

Country_____ Country _____

ZIP / Postal Code _____-_____ ZIP / Postal Code _____- _____

Daytime Phone _____ Evening Phone_____

Cellular Phone _____Preferred Contact Number (circle): Day Eve Cell

If you are covered by Medicaid (including Medicaid Managed Care Plans administered by Healthplex or Dentaquest), please complete the following:

New York State Department of Social Services BENEFIT Identification Card

ID Number /___/___/___/___/___/___/___/___/___/

Name: _____ Sex : M F

Birth Date: _____

Signature of Applicant:_____ Date:_____

Pt App Rev. 6/29/16 rlc