UNIVERSAL DENTAL LABORATORIES LTD.

In-Lab Patient Therapy Authorization Form

DENTAL OFFICE *Must Complete (please print & check where appropriate)*

Name of Doctor _____

Please select procedure(s): *** $105.00 per procedure will be charged ***

- ☐ Upper Impression
- ☐ Lower Impression
- ☐ Bite Registration
- ☐ Try-in
- ☐ Insert

Instructions: _____

Please select billing method:

- ☐ Invoice to dental office
- ☐ Patient pays at lab **(Lab bill to patient CANNOT be used for Tax Deduction/Insurance Reimbursement submission)**

PATIENT INFORMATION *(please print & circle where appropriate)*

Mr / Mrs / Ms _____ (Last) _____ (First) _____ (Middle)

Daytime Tel: _____ Cell: _____

Any allergies/medical conditions (latex / hepatitis / HIV etc.)? _____

Appointment Booked on: _____ mm _____ dd _____ yy Time: _____ AM / PM

_____ Authorized Signature *(Dental Office)* _____ Name _____ mm dd yy Date

Please FAX Completed Form with Signature to 780.429.0809

FOR LAB USE

I, patient _____ Name hereby acknowledge receipt of my _____ Appliance in good order.

_____ Patient Signature _____ mm dd yy Date

073018

All in-lab patient charges/procedures are subject to change without prior notice.

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