UNIVERSAL DENTAL LABORATORIES LTD.

2025 In-Lab Patient Therapy Authorization Form

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

Name of Doctor ______________________

Please select procedure(s): *** $118.50 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 ______________ Date mm dd yy

Please FAX Completed Form with Signature to 780.425.4610

FOR LAB USE

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

Patient Signature ______________ Date mm dd yy

01/01/2022

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