PLEASE COMPLETE AND BRING TO APPOINTMENT

THE UNIVERSITY OF IOWA
COLLEGE OF DENTISTRY & DENTAL CLINICS

COLLEGE OF DENTISTRY
PATIENT REGISTRATION

The University of Iowa College of Dentistry and Dental Clinics and the Hospital Dentistry Institute requests this information for the purposes of providing a complete and comprehensive evaluation of your dental needs. No persons outside the University will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and may result in the College being unable to accept you as a patient.

PATIENT DATA

☐Mr ☐Mrs ☐Rev ☐Ms ☐Miss ☐Dr | Print full legal name: last first middle

☐ Female ☐ Male ☐Transgender | Date of Birth: *(Month/Day/Year)* | Social Security # (last 4 only) : | Preferred Name:

Mailing Address: Apt. # PO Box #

City: | State: | Zip Code: | Email:

Home Phone # *(with area code)* | Work Phone # *(with area code and ext.)* | Cellular/Other Phone # *(with area code)*

Preferred Phone Number to Contact Patient: ☐ Home ☐ Work ☐ Other | Please contact me by: ☐ Phone ☐ Email ☐ Text *(Please check all that apply)*

Alternate/Permanent Address *(If different than above)* | City: | State: | Zip Code:

EMERGENCY CONTACT INFORMATION *(Required by law)*

Emergency Contact: last first middle

Relationship: | Home Phone # *(with area code)* | Other Phone # *(with area code)* | Email Address:

Mailing Address: | City: | State: | Zip Code:

BILLING ADDRESS

☐ ***Same as above Mailing Address***

Billing Address: City State Zip Code

RESPONSIBLE PARTY INFORMATION

☐ **Same as Patient**

Print full legal name: last first middle | Relationship to Patient:

Mailing Address: | City: | State: | Zip Code:

Home Phone #*(with area code)* | Cellular/Other Phone # *(with area code)* | Date of Birth:*Month/Day/Year* | Email Address:

INSURANCE/PAYMENT INFORMATION

Dental Insurance ☐ Yes ☐ No | DWP ☐ Yes ☐ No | Medicaid (Title XIX) ☐ Yes ☐ No | Medical Insurance ☐ Yes ☐ No | Agency ☐ Yes ☐ No

	NAME OF POLICY HOLDER (IN ORDER OF FILING)	*POLICY HOLDER BIRTHDATE* ***(REQUIRED)***	POLICY HOLDER ADDRESS (IF DIFFERENT THAN PATIENT)	INSURANCE Policy ID #	INSURANCE CARRIER NAME	M/D (MEDICAL/DENTAL)	EMPLOYER NAME
1							
2							
3							
4							

PATIENT DEMOGRAPHICS

The following optional information is collected to better track the demographics of our patient population

Ethnicity ☐ White/Caucasian ☐ Asian ☐ Hispanic ☐ Black/African American ☐ Other _____

Language Preference: ☐ English ☐ Spanish ☐ Other: _____

How did you hear about us?
☐ College of Dentistry Patient ☐ Friend/Family ☐ Health Fair/Local Event ☐ Internet ☐ Phone Book ☐ Social Media
☐ Radio ☐ Newspaper ☐ TV ad ☐ Bus ad ☐ Other _____
☐ Referring Dr.: _____ City/State:_____