

**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

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Rev <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr		Print full legal name: last first middle		
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender		Date of Birth: (Month/Day/Year)	Social Security # :	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: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other			Please contact me by: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Text <i>(Please check all that apply)</i>	
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

<input type="checkbox"/> Same as above Mailing Address			
Billing Address:	City	State	Zip Code

RESPONSIBLE PARTY INFORMATION

<input type="checkbox"/> Same as Patient			
Print full legal name: last first middle		Relationship to Patient:	Social Security #:
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 <input type="checkbox"/> Yes <input type="checkbox"/> No		DWP <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid (Title XIX) <input type="checkbox"/> Yes <input type="checkbox"/> No		Medical Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		Agency <input type="checkbox"/> Yes <input type="checkbox"/> No	
1	NAME OF POLICY HOLDER <small>(IN ORDER OF FILING)</small>	POLICY HOLDER BIRTHDATE <small>(REQUIRED)</small>	POLICY HOLDER ADDRESS <small>(IF DIFFERENT THAN PATIENT)</small>	INSURANCE ID	INSURANCE CARRIER NAME	M/D <small>(MEDICAL/DENTAL)</small>	EMPLOYER NAME		
2									
3									
4									

PATIENT DEMOGRAPHICS

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

Ethnicity <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic		Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish	
<input type="checkbox"/> Black/African American <input type="checkbox"/> Other _____		<input type="checkbox"/> Other: _____	
How did you hear about us?			
<input type="checkbox"/> College of Dentistry Patient <input type="checkbox"/> Friend/Family <input type="checkbox"/> Health Fair/Local Event <input type="checkbox"/> Internet <input type="checkbox"/> Phone Book <input type="checkbox"/> Social Media <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> TV ad <input type="checkbox"/> Bus ad <input type="checkbox"/> Other _____ <input type="checkbox"/> Referring Dr.: _____ City/State: _____			