College of Dentistry and Dental Clinics

Department of Operative Dentistry

Faculty General Practice Clinic

244 Dental Science Building South
Iowa City, IA 52242-1001
319-335-8232 (FACULTY)
Fax: 319-353-5375

Resident Clinic

319-335-7217 (RESIDENTS)
Fax: 319-335-5399

FACULTY PRACTICE

Amira Ahmed, DDS
Steven R. Armstrong, DDS, PhD, FADM
Hanan Elgendy, DDS, MS
Sandra Guzman-Armstrong, DDS, MS
Aditi Jain, BDS, MS
Justine Kolker, DDS, MS, PhD
Patricia K. Meredith, DDS, MS, MAGD
Natalia Restrepo-Kennedy, DDS, MS
Rodrigo Rocha Maia, DDS, MS, PhD
Erica Teixeira, DDS, MS, PhD
Cristina Vidal, DDS, MS, PhD

Date: ____________________

Patient legal name: ________________________________ Date of birth: _____________ Gender:_________

Patient address: ____

Patient phone: _______________________________________ Cell phone: ______________________________

Name of dental insurance: ______________________________ E-mail: __________________________________

Requested consultation/treatment restorative/esthetic dentistry;

☐ Consultation only

☐ Consultation and limited treatment

  ☐ Return to referring dentist

☐ Comprehensive care

Reason for referral (Please be specific): ____

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Please contact the Faculty General Practice Clinic (319.335.8232) or Operative Dentistry Resident Clinic (319.335.7217) to set up an appointment.

Level of care requested:

☐ Operative resident. Patients are seen in the Operative Dentistry Resident Clinic.

☐ Faculty *(see list below)*. Patients are seen in the Faculty General Practice Clinic.

☐ Ahmed	☐ Jain	☐ Rocha Maia	☐ *Faculty with first available appointment*
☐ Armstrong	☐ Kolker	☐ Teixeira	
☐ Elgendy	☐ Meredith	☐ Vidal	
☐ Guzman-Armstrong	☐ Restrepo-Kennedy		

Radiographs preferred on film or compact disc:

☐ Enclosed ☐ None provided

To transfer patient records and radiographs electronically, please use our HIPAA compliant and secure website. Call Central Records at 319-335-7429 for instructions. Include your office name/phone number, patient name/date of birth, and date radiographs made.

Referring dentist: ____

Address: ____

Telephone: ___________________________________ E-mail: ___________________________________