UnityPoint Health
St. Luke's Hospital

St. Luke's Dental Health Center

Patient Information

Patient's Legal Name: ______________________________ Preferred Name: __________
First MI Last

Address: ______________________________ City: __________________ Zip Code: __________

Home Phone: ____________________ Cell Phone: ____________________ Sex: ___ M ___F

Date of Birth: ______________ Age: ______

Who is the patient living with? ______________________ Relationship: ____________________

Please check patient's race: White Black Hispanic Asian Multicultural Other

Parent / Guardian #1

Name ____ Relationship ________________________

Address (If different than above) ____

City/Zip Code ________________________________ Home Phone ________________________

Cell Phone ____________________ Work Phone ________________________

Employer ______________________________ Can a message be left at work? ____ Yes ____No

Parent / Guardian #2

Name ____ Relationship ________________________

Address (If different than above) ____

City/Zip Code ________________________________ Home Phone ________________________

Cell Phone ____________________ Work Phone ________________________

Employer ______________________________ Can a message be left at work? ____ Yes _____No

Do you have: Medicaid (Title XIX) ____Yes ____No Identification Number ____________________

Hawk-I ____Yes ____No Identification Number ____________________

Do you have: Private Dental Insurance ____Yes ____No If Yes, Please answer the following questions:

Primary Insurance Company ____

Primary Insurance Address ____

Subscriber's Name __________________________ Relationship to the Patient ____________________

Subscriber's Address ____ Phone __________________

Social Security Number ______________________ Date of Birth ______________________________

Subscriber's Employer/Address ____

Reviewed: 9/18