



DUBUQUE DENTAL ASSOCIATES, PC
DR. TJARKS, DR. KILBURG, DR. STUNTZ
1890 JOHN F KENNEDY ROAD
DUBUQUE, IOWA 52002-3810

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
 Address: _____ Address 2: _____
 City, State, Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Birth Date: _____ Soc Sec: _____ Drivers Lic: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
 City: _____ State / Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ Soc. Sec.: _____ Drivers Lic: _____
 E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired
 Student Status: Full Time Part Time
 Medicaid ID: _____ Pref. Dentist: _____
 Employer ID: _____ Pref. Pharmacy: _____
 Carrier ID: _____ Pref. Hyg.: _____

Section 3

Emergency Contact: _____
 Emergency Number: _____
 Physician: _____
 Spouse: _____
 Spouse work #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____
 Employer: _____ Ins. Company: _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City,State,Zip: _____ City,State,Zip: _____
 Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____
 Employer: _____ Ins. Company: _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City,State,Zip: _____ City,State,Zip: _____
 Rem. Benefits: _____ .00 Rem. Deduct: _____ .00