UnityPoint Health
St. Luke's Hospital

FOR OFFICE USE ONLY
DATE SENT_____
DATE REC'D _____
QUALIFIES @_____%
❑ REQUAL. ❑ DOES NOT QUALIFY
INITIALS_____

ST. LUKE'S DENTAL HEALTH CENTER
855 A Avenue NE, Suite LL1
Cedar Rapids IA 52402
PHONE 319-369-7730

APPLICATION FOR QUALIFICATION OF DENTAL SERVICES

Parent(s)/Guardian(s) Name

_____
(Last) (Mr.) (Mrs.)

Address_____

City/Zip Code_____

Telephone_____ **Total number of persons living in the home**_____

Dental Coverage: ❑ **Private Insurance** ❑ **Title 19/Medicaid** ❑ **hawk-i** ❑ **None**

Gross Monthly Household Income (Verification must be attached!)

Parental Income_____

Other Adult Income_____

Other Income_____**Source**_____ **(Child Support/Alimony etc.)**

Total Income_____

Name, Age/Birthdate, and Social Security number of Children:

Name	Age/Birthdate	SS#
Name	Age/Birthdate	SS#
Name	Age/Birthdate	SS#
Name	Age/Birthdate	SS#
Name	Age/Birthdate	SS#
Name	Age/Birthdate	SS#

_____
_____
Signature of Parent/Guardian **Date**