Waukesha County Community Dental Clinic Registration Form

Patient name: ____ Gender: Male / Female (circle one)

Birth date: _____/_____/________ S.S.N.: _______-_______-______

Street Address: ____

City: ____________________________ State: ___________ Zip Code: _______________

Phone: Home (____) _____-_____________ Work (____) _____-____________Cell (____) _____-___________

Insurance: (circle one) BadgerCare & Medicaid / None

Who referred patient to this clinic? ____________________________________

Patient's last dental appointment: _____________________________________

Patient's Marital Status: (circle one) Single / Married / Widowed / Divorced / Separated

Race/Ethnic group:

___ American Indian or Alaskan Native
___ Asian or Pacific Islander
___ Black (not of Hispanic Origin)
___ Hispanic
___ White (not of Hispanic Origin)
___ other _________________________

Parent information for <u>child under 18</u> (or guardian, if applicable):

Name of parent/guardian: ____

Address (if different from above):____

Relationship to patient: ____

Name of parent/guardian: ____

Address (if different from above):____

Relationship to patient: ____

WCCDC Attendance Policies **(please initial and date the following)**

Patients who have one no show cannot reschedule for 6 months. A second no show will result in termination of services at WCCDC. **Initial** ____ **Date** __________

Patients who do not call to cancel an appointment the day before the appointment or do not leave a message on the cancellation line will be designated a no show. **Initial** ____ **Date** __________

Patients are responsible to call WCCDC with phone number changes. WCCDC will cancel appointments for patients with disconnected numbers. **Initial** ____ **Date** __________

Patients who no show due to an emergency may bring in appropriate documentation to be removed from the no-show list. **Initial** ____ **Date** __________

Patients who arrive more than 10 minutes late for an appointment will be rescheduled. A second tardy visit will be considered a no-show. **Initial** ____ **Date** __________

Uninsured patients must bring proof of family income and residency to each appointment. Those with the Forward Card must bring the card to each appointment. **Initial** ____ **Date** __________

(Please Turn Over)

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Services Provided by WCCDC

<u>For Children and Pregnant Women:</u>
- Routine exams and cleanings
- Education on preventative care
- Basic fillings
- Root canals and crowns

<u>We Do Not Provide</u>
- Braces
- Oral or IV sedation

<u>Treatment options for Children and Pregnant Women</u>
The clinic dentist, student or volunteer will inform you of a treatment plan(s) that is in best interest of the patient's dental and medical health.

<u>For Adults</u>
- Emergency care for pain and/or infection, which includes only antibiotics and extractions.
- WCCDC does not provide cleanings, fillings, or denture work for adults.

<u>Please Note:</u>
If you agree to have some or all of your teeth extracted (removed) WCCDC will **NOT** provide the replacement of the extracted teeth with a denture or a bridge. Should you agree to have all your teeth removed for dentures, this will only be done **after** you have a scheduled appointment with a dentist you have contacted to fit you for dentures.

Please initial and sign below:
1. I certify that the above information is true. I authorize WCCDC to verify all household income. This information will only be used as documentation and will be kept confidential and in a secure location. **Initial** ____ **Date** __________

2. I acknowledge and agree to dental service/treatments that may be provided by WCTC and MATC hygiene students or Marquette University dental student supervised by a licensed dentist. **Initial** ____ **Date** __________

3. I understand that all children under 18, including those in waiting room, must be supervised by a parent or legal guardian at every visit. Children accompanying patients receiving treatment are not allowed in the treatment room. **Initial** ____ **Date** __________

4. I understand co-pays are **<u>required</u>** at every appointment and may only be paid in **<u>cash</u>**. **Initial** ____ **Date** ________

5. I understand the **No Show/Late Arrival** policies. **Initial** ____ **Date** __________

6. I give permission to WCCDC to photograph me/my child. **Initial** ____ **Date** __________

I have read and understand WCCDC's policies and treatment information.

Signature: ____ Date: ________________________________

9/2011