Community
Smiles Dental

REGISTRATION FORM

Patient Last Name: _____ **First Name**: _____
Gender: _____ **Birth date:** _____/_____/_____
Street Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Primary Phone: (_____) _____-_____ **Secondary Phone:** (_____) _____-_____

Insurance: (circle one) Insured / Uninsured
Who referred this patient to this clinic? _____

Race/Ethnic group:
____ American Indian/ Alaskan Native ____Asian ____ Hispanic ____Native Hawaiian/ Pacific Islander
____ White ____ Black ____ Middle Eastern ____Multiracial _____Other_____

Parent information for child under 18 (or guardian, if applicable):
Name of parent/guardian: _____Relationship to patient: _____
Address (if different from above): _____
Name of parent/guardian: _____Relationship to patient: _____
Address (if different from above): _____

CLINIC POLICIES

1. I acknowledge that I have had the opportunity to review a copy of the Notice of Privacy Practice and Rights & Responsibilities posted within the clinic.
2. We require 24-hour notice to cancel appointments. If your child is ill the morning of their appointment, please call the clinic to cancel their appointment as soon as possible.
3. **Voicemails left by CSD staff to confirm appointments require a CALL BACK to the clinic to confirm the appointment by 1pm the day before the appointment, otherwise the appointment will be cancelled.**
4. Patients are responsible for communicating phone number changes. CSD **will cancel appointments for patients with disconnected numbers.**
5. A failed/missed appointment occurs when a patient does not show for a confirmed appointment or arrives 10 or more minutes late to a confirmed appointment. Patients who have **one failed appointment may be rescheduled 6 months out. Two failed appointments within two years will result in termination** ("FIRED") of services at the clinic.
6. **Previously "FIRED" patients may remain "FIRED"**.
7. Patients who miss a scheduled appointment due to an emergency may bring in appropriate documentation to be reinstated to the clinic.
8. 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.
9. I authorize CSD to verify all household income. This information will only be used as documentation and will be kept confidential and in a secure location.
10. I acknowledge and agree to dental service/treatments that may be provided by dental students supervised by a licensed dentist.

For office use only: Date of First Appointment: _____Location: Waukesha/Menomonee Falls Co-Pay Amount $30 / $35 / $40

11. I understand that children under 18 need to be accompanied to appointments by a parent/guardian. I understand that any adult bringing a patient for an appointment must remain in the waiting room during the patient's appointment due to clinic safety rules and policy.
12. I understand co-pays are **required** at every appointment and credit card payment is preferred.
13. I give permission to CSD to share dental information with other referral sources.
14. I have reviewed and signed the CSD's photo consent form. I give permission for CSD to photograph me/my child.
15. I understand that chronic non-compliance (failure to cooperate with the dental care plan) or rude/disrespectful behavior toward staff will result in termination of services at CSD.
16. I understand that per the CSD's Snow Day policy, if the school districts cancel school for the day due to severe weather, my child's dental appointment will also be cancelled and I will not receive a personal phone call confirming this.
17. I understand that the CSD has the right to refuse treatment of my child in the event that my child/patient presents to the office with any signs of illness or a condition that could be detrimental to other patients and/or staff, the patient will be rescheduled to a later date and will not be seen as scheduled.

I certify that the above information is true. I have read and understand all CSD's policies and treatment information.

Signature: _____ Date: _____

APPOINTMENT AVAILABILITY

New Patients will be called on a **cancellation basis**. In order for the CSD to better serve your needs we will try our best to accommodate your schedule. Please indicate the best days and times your child is AVAILABLE to have an appointment and we will try to contact you to schedule your New Patient appointment for your preferred days and times.

Parent/guardian name: _____ Phone number: _____

Parent/guardian name: _____ Phone number: _____

Child Name	DOB and age:	Medicaid/ Forward ID #

Please circle the best day(s) and time(s) you are available for a New Patient appointment.

Our clinic hours are as follows: Monday-Thursday 8:00 AM – 4:30 PM and Friday 8:00 AM – 2:00 PM

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	AM	AM	AM	AM
PM	PM	PM	PM	PM

Notes: _____

_____

The parent/guardian is responsible to contact the clinic if there is a change in contact information or if the patient has not received an appointment AFTER 90 days from registration date

For clinic use: 1st attempt: _____ 2nd attempt: _____ 3rd attempt: _____