Community
Smiles **Dental**

2023 ADULT PROGRAM REGISTRATION FORM

Patient Last Name: _____**First Name**_____

Gender: _____ **Birth date**: _____/_____/_____

Street Address: _____ **City:** _____ **Zip Code:** _____

Mobile/Cell Phone: (_____) _____-_____ **Secondary Phone:** (_____) _____-_____

Email Address: _____

Who referred this patient to this clinic? Please check one:
____Primary Care Physician ____ Urgent Care/Emergency Room ____ Your Insurance ____ Family or Friend
____Church ____ Social Service Agency ____ Internet ____ Other dental office referred me

What is the primary Language spoken in the home? _____ English _____Spanish _____Hmong
____ Multiple languages spoken _____Other: _____

Race/Ethnic group:
____ American Indian/Alaskan Native ____Asian ____ Hispanic ____Native Hawaiian/ Pacific Islander
____ White ____ African American/Black ____ Middle Eastern ____ Multi-racial _____Other:_____

Dental Insurance: _____ BadgerCare/Medicaid _____ None/Uninsured

Authorization to Leave Personal Health Information

It is frequently necessary for personnel at CSD to communicate with our patients regarding dental treatment and other protected health information.

The following individual has my permission to discuss my health condition(s) or act on my behalf:

Name: _____ Relationship to patient: _____
Phone: _____

For Office Use Only:**Annual Income:** $_____ **Family Size**: _____ **Pregnant:** Yes No **New or Returning Patient (Circle)** **Updated March 2021**

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Clinic Policies

1. I acknowledge that I have had a chance to review the posted copy of CSD's Notice of Privacy Practice and CSD's Rights & Responsibilities.
2. We require 24-hour notice to cancel appointments. If you are ill the morning of their appointment, please call the clinic to cancel your 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 to call CSD with phone number changes. CSD will cancel appointments for patients with disconnected numbers.
5. A failed/missed appointment occurs when a patient arrives 10 or more minutes late for an appointment, or fails to keep a confirmed scheduled appointment. Patients with one failed/missed appointment will lose the privilege to participate in the adult program.
6. Patients who fail a scheduled appointment due to an emergency may bring in appropriate documentation to be reinstated to the clinic.
7. 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.
8. 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.
9. I acknowledge and agree to dental service/treatments that may be provided by MATC/WCTC hygiene students or Marquette University dental students supervised by a licensed dentist.
10. I understand co-pays are **required** at every appointment and that credit card payment is preferred.
11. I give permission to CSD to share dental information with other referral sources.
12. I have reviewed and signed the CSD's photo consent form. I give permission for CSD to photograph me.
13. 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.
14. I understand that the CSD has the right to refuse treatment in the event that I present to the office with any signs of illness or a condition that could be detrimental to other patients and/or staff, I 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 of CSD's policies and treatment information.

Signature: _____ Date: _____