Community
Smiles **Dental**

2023 REGISTRATION FORM

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

Dental Insurance: _____BadgerCare/Medicaid _____ None/Uninsured

Who referred this patient to this clinic? Please check one:
____Primary Care Physician ____Urgent Care/Emergency Room ____School ____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 ____ 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 canceled.**
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"**.

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

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.
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 to an appointment needs to remain in the waiting room during the 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 canceled 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: _____

CONSENT TO PHOTOGRAPH/VIDEOTAPE AND RELEASE

I hereby authorize Community Smiles Dental ("CSD"), its employees, volunteers, affiliates, or agents, to photograph, film videotape, produce other illustrative material, and/or make audio recordings (collectively, the "Recordings") of me and/or my children listed below in connection with CSD.

I further authorize CSD to use and/or reproduce such Recordings/photographs, in whole or in part, for the scientific, educational, or informational purposes of CSD, including, but not limited to, use on any CSD Web-based media.

I hereby release CSD, its employees, affiliates, or agents, from any and all claims and demands arising out of, or in connection with, its use of the Records pursuant to this agreement, including, but not limited to, any claims of defamation or invasion of privacy.

I hereby represent that I have the appropriate authority to execute this agreement and fully understand the contents hereof.

Name(s) of Children (Please print)

Name of Parent/Guardian (Please Print) **Date**

Signature of Parent/Guardian

☐ **I do NOT wish to be taped**