



2026 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 December 2024



Clinic Policies

HIPAA/Consent to Treat

1. I acknowledge that I have a chance to review-a copy of CSD's Notice of Privacy Practice and CSD's Rights & Responsibilities upon request.
2. By signing this form, I am giving my consent for Community Smiles Dental to treat my dental needs. I understand that CSD will bill my insurance for treatment provided and submit information about my dental record to insurance as needed.
3. 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.
4. I give permission to CSD to share dental information with other referral sources.

Confirming Appointments/Attendance

5. We require 24-hour notice to cancel appointments. If you are ill the morning of your appointment, please call the clinic to cancel your appointment as soon as possible.
6. **An electronic communication system will send emails and texts to confirm appointments. Appointments must be confirmed by 1pm the day before the appointment, otherwise the appointment will be canceled.**
7. Patients are responsible to call CSD with phone number changes. CSD will cancel appointments for patients with disconnected numbers.
8. 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.
9. Patients who fail a scheduled appointment due to an emergency may bring in appropriate documentation to be reinstated to the clinic.

Billing to Insurance+Uninsured/Income Qualification

10. Uninsured patients must bring proof of family income and proof of address to each appointment. Those with the Forward Card must bring the card to each appointment
11. Co-pays are **required** for those who are uninsured at every appointment and credit card payment is preferred.
12. 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.

Safety

13. I understand that chronic non-compliance (failure to cooperate with the dental care plan) or disrespectful behavior toward staff will result in termination of services at CSD.
14. I understand that 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: _____