More Smiles Wisconsin Dental Clinic Application

Patient Information

Last:_________________________ First:____________________ MI:____

Street Address:____________________________________City:_____________________ Zip:_________

Phone Number: (cell)______________________ (home or other):_______________________

Date of Birth:_____/_____/_______ Gender: ☐ Male ☐ Female

Emergency Contact: ____________________ Relationship: __________Phone Number:_______________

Dental Insurance Status: ☐ Badgercare (Forward Health Card) ☐ No Dental Insurance

Housing Status: ☐ Own ☐ Rent ☐ Family/Friends ☐ Homeless ☐ Other:_________________

Marital Status: ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐ Domestic Partnership ☐ Single

Race/Ethnic Group:

☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black or African American
☐ Hispanic ☐ White/Caucasian ☐ Hmong ☐ Other: ____________

Employment Status:

☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Self-employed

☐ Retired ☐ Receiving SSI/Disability ☐ Other:______________________

Are you a veteran? ☐ Yes ☐ No

Parent/Guardian information for child under age 18 (if applicable):

Name of parent/guardian:_________________________________ Relationship to child:_______________

Patient Release Form: I give More Smiles Wisconsin and its delegates permission to discuss, arrange, or otherwise coordinate my dental care with only the below individual(s) in an effort to stream-line and ensure quality care. Topics that may be discussed with the individual include appointment set-ting and schedules, details of procedures, medical/dental history, medications, medicals images (x-rays).

Individual(s) Granted Access: ____

Relationship to Patient: ___________________ Phone Number: _______________________

☐ Please check this box to indicate we cannot share information regarding your care

How did you hear about us?

☐ Internet ☐ Access ☐ Friend/Family ☐ Dane Cares ☐ Salvation Army ☐ United Way/211

☐ Dean ER ☐ UW ER ☐ Medic ☐ Badgercare ☐ Other (specify):_______________________

I hereby authorize More Smiles Wisconsin's Dentists and their team to perform upon myself dental procedures which may include the use of anesthetic and surgical equipment. I understand that if I have questions or con-cerns, I can express them to the Dentist before the procedure is performed and he/she will talk with me about the risks and benefits of the procedure and any alternatives that may exist. My signature on this form certifies that I authorize More Smiles Wisconsin to use the above information for its end of year demographic analysis and also certifies that I have received a copy of More Smiles Wisconsin's Notice of Privacy Practices.

Signature of patient or guardian:_________________________________ **Date:**_____/_____/