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 ☐ Separated ☐ 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 ☐ Retired ☐ Receiving SSI/Disability
☐ Self-Employed ☐ 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, medical/dental history, medications, medicals images (x-rays).

Relationship to Patient: _____ Phone Number: _____

How did you hear about us?
☐ Internet ☐ Access ☐ Friend/Family ☐ Dane Cares ☐ Salvation Army ☐ United Way/211 ☐ Dean ER
☐UWER ☐ 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:____/____/____