

PATIENT INFORMATION

Welcome to More Smiles Wisconsin!

This confidential information will help us prepare for your visit.

LAST NAME		FIRST NAME		MI	I PREFER TO BE ADDRESSED AS	
BIRTHDATE ____/____/____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER _____			PREFERRED GENDER PRONOUNS		
STREET ADDRESS			CITY		STATE	ZIP CODE
HOME PHONE #		CELL PHONE #		WORK PHONE #		
YOUR EMAIL		ARE YOU A VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		DENTAL INSURANCE STATUS <input type="checkbox"/> BADGERCARE (FORWARD HEALTH) <input type="checkbox"/> UNINSURED		
MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPERATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DOMESTIC PARTNERSHIP						
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE #		EMERGENCY CONTACT RELATIONSHIP		
<p>PATIENT RELEASE</p> <p>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 streamline and ensure quality care. Topics that may be discussed with the individual include appointment setting and schedules, details of procedures, medical/dental history, medications, medicals images (x-rays).</p> <p>INDIVIDUALS(S) GRANTED ACCESS _____</p> <p>RELATIONSHIP TO PATIENT _____ PHONE NUMBER _____</p>						
<p>WHY DO WE ASK YOU THE FOLLOWING QUESTIONS?</p> <p>More Smiles Wisconsin relies heavily on outside financial support. The information gathered on this form helps us secure funding so we can continue to provide affordable dental care to our patients.</p>						
<p>HOUSING STATUS</p> <p><input type="checkbox"/> OWN <input type="checkbox"/> RENT <input type="checkbox"/> FAMILY/FRIENDS <input type="checkbox"/> HOMELESS <input type="checkbox"/> OTHER _____</p>						
<p>EMPLOYMENT STATUS</p> <p><input type="checkbox"/> EMPLOYED FULL-TIME <input type="checkbox"/> EMPLOYED PART-TIME <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> RECEIVING SSDI/DISABILITY</p> <p><input type="checkbox"/> RETIRED/SSI <input type="checkbox"/> OTHER _____</p>						
<p>RACE</p> <p><input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN</p> <p><input type="checkbox"/> NATIVE HAWAIIAN OR PACIFIC ISLANDER <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER _____</p>				<p>ETHNIC GROUP</p> <p><input type="checkbox"/> HISPANIC OR LATINO</p> <p><input type="checkbox"/> NOT HISPANIC OR LATINO</p>		
<p>DO YOU HAVE ANY DISABILITIES/DIFFICULTIES YOU WANT US TO BE AWARE OF? <input type="checkbox"/> NO</p> <p><input type="checkbox"/> HEARING <input type="checkbox"/> VISION <input type="checkbox"/> COGNITIVE <input type="checkbox"/> AMBULATORY <input type="checkbox"/> SELF-CARE <input type="checkbox"/> OTHER _____</p>						
<p>PARENT/GUARDIAN INFO FOR CHILD UNDER AGE 18 (IF APPLICABLE)</p> <p>NAME OF PARENT/GUARDIAN _____ RELATIONSHIP TO CHILD _____</p>						
<p>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 concerns, 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.</p>						
<p>Signature of patient or guardian: _____ Date: ____/____/____</p>						

PATIENT MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you been hospitalized or had a major operation in the last 3 years?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux or chemotherapy drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate medications or other osteoporosis drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you have any blood disorders?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you have diabetes or hyper/hypoglycemia?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you have, or have you had, any heart conditions?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you have, or have you had, Cancer, chemotherapy, or radiation treatments?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you have any artificial joints? Year of replacement?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you have any lung diseases or other breathing impairments?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Medications

Are you taking any medications, pills, or drugs? If yes, please list below ☐ Yes ☐ No

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Do you have...

☐ Herpes ☐ AIDS/HIV Positive ☐ Hepatitis A ☐ Hepatitis B or C

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No
Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Liver Problems <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No
Gastrointestinal Problems <input type="radio"/> Yes <input type="radio"/> No	Blood Thinners <input type="radio"/> Yes <input type="radio"/> No	Seizures/Epilepsy <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No
Thyroid/Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Anemia <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No
Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Name of patient: _____

Signature of patient or guardian: _____

Date: ____/____/____

1. I acknowledge that I have received a copy of MSW's Notice of Privacy Practices
2. I understand that it is my responsibility to clarify if I have co-pays and balances prior to appointments
3. I understand that co-pays are due at the time of service unless other payment arrangements have been made in advance with MSW staff.
4. I understand that if my insurance denies my coverage I am responsible for the full costs of the treatment I received (will receive), at MSW as determined by sliding scale fees.
5. I understand that I am responsible for reporting phone number or address changes to MSW staff.
6. I understand that if I do not confirm an appointment **24 hours** before or do not leave a message, that appointment could be cancelled by MSW due to extreme need and limited availability of dental appointments.
7. I understand that if I fail twice to show up for general/hygiene appointments or once for a root canal without 24-hour notice to MSW, I will be discharged from the program and cannot reapply for one year (except in the case of an emergency).
8. I understand that if I fail to keep an appointment due to an emergency, I can bring in appropriate documentation which will keep me admitted into the program.
9. I understand that if I arrive more than **10 minutes** late for an appointment without notifying MSW staff, my appointment will be marked as missed/failed and I will not be seen that day.
10. I understand that MSW may use my information in order to apply for funding that supports the clinic
11. I understand that I must conduct myself in a civil and respectful manner to MSW and Salvation Army staff. If I do not, I will be asked to leave the clinic and permanently discharged from

Name of patient: _____

Signature of patient or guardian: _____

Date: ____/____/____