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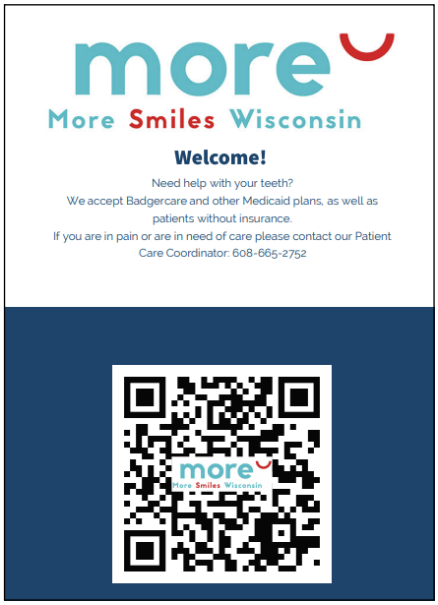
More Smiles Wisconsin
– Community Dental Care –

HOW DID YOU HEAR ABOUT US?

This information will help us to ensure we are reaching as many people as possible

Have you seen one of the cards below? If yes, please select which one:

☐ QR CODE



☐ BUSINESS CARD

If you heard about us a different way, please let us know!

Select one of the options below:

☐ MEDiC
☐ FAMILY/FRIENDS
☐ FACEBOOK
☐ BADGERCARE
☐ SSM ER
☐ UW ER
☐ MERITER ER
☐ UNITED WAY/211
☐ GOOGLE
☐ SALVATION ARMY
☐ ACCESS COMMUNITY HEALTH
☐ A MEDICAL PROVIDER OUTSIDE OF ER/UC SETTING
☐ OTHER _____

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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 ☐ MALE ☐ FEMALE ☐ OTHER _____	PREFERRED GENDER PRONOUNS

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE #	CELL PHONE #	WORK PHONE #

YOUR EMAIL	ARE YOU A VETERAN? ☐ YES ☐ NO	DENTAL INSURANCE STATUS ☐ BADGERCARE (FORWARD HEALTH) ☐ UNINSURED

MARITAL STATUS
☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ SEPARATED ☐ WIDOWED ☐ DOMESTIC PARTNERSHIP

EMERGENCY CONTACT	EMERGENCY CONTACT PHONE #	EMERGENCY CONTACT RELATIONSHIP

PATIENT RELEASE

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).

INDIVIDUALS(S) GRANTED ACCESS _____

RELATIONSHIP TO PATIENT _____ PHONE NUMBER _____

WHY DO WE ASK YOU THE FOLLOWING QUESTIONS?

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.

HOUSING STATUS
☐ OWN ☐ RENT ☐ FAMILY/FRIENDS ☐ HOMELESS ☐ OTHER _____

EMPLOYMENT STATUS
☐ EMPLOYED FULL-TIME ☐ EMPLOYED PART-TIME ☐ UNEMPLOYED ☐ SELF- EMPLOYED ☐ RECEIVING SSDI/DISABILITY
☐ RETIRED/SSI ☐ OTHER _____

RACE
☐ INDIGENOUS OR AMERICAN INDIAN ☐ BLACK OR AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ ASIAN ☐ WHITE ☐ OTHER _____

ETHNIC GROUP
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO

DO YOU HAVE ANY DISABILITIES/DIFFICULTIES YOU WANT US TO BE AWARE OF? ☐ NO
☐ HEARING ☐ VISION ☐ COGNITIVE ☐ AMBULATORY ☐ SELF-CARE ☐ OTHER _____

PARENT/GUARDIAN INFO FOR CHILD UNDER AGE 18 (IF APPLICABLE)

NAME OF PARENT/GUARDIAN _____ RELATIONSHIP TO CHILD _____

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.

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

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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?	◯ Yes ◯ No	If Yes:
Have you been hospitalized or had a major operation in the last 3 years?	◯ Yes ◯ No	If Yes:
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If Yes:
Do you take, or have you taken, Phen-Fen or Redux, or chemo-therapy drugs?	◯ Yes ◯ No	If Yes:
Have you ever taken Fosamax, Boniva, Actonel, or any other bisphosphonate medications or any other osteoporosis drugs?	◯ Yes ◯ No	If Yes:
Are you on a special diet?	◯ Yes ◯ No	If Yes:
Do you use tobacco?	◯ Yes ◯ No	If Yes:
Do you use controlled substances?	◯ Yes ◯ No	If Yes:
Do you have any blood disorders?	◯ Yes ◯ No	If Yes:
Do you have diabetes or hyper/hypoglycemia?	◯ Yes ◯ No	If Yes:
Do you have, or have you ever had, any heart conditions?	◯ Yes ◯ No	If Yes:
Do you have, or have you ever had, Cancer, chemotherapy, or radiation treatments?	◯ Yes ◯ No	If Yes:
Do you have artificial joints? Year of replacement?	◯ Yes ◯ No	If Yes:
Do you have any lung diseases or other breathing impairments?	◯ Yes ◯ No	If Yes:
Do you require a pre-medication?	◯ Yes ◯ No	If Yes:

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 ever had, any of the following?

Alzheimer's disease	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Frequent Diarrhea	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Hay Fever	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Liver Problems	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Gastrointestinal Problems	◯ Yes ◯ No	Blood Thinners	◯ Yes ◯ No	Seizures/Epilepsy	◯ Yes ◯ No	Fainting Spells/ Dizziness	◯ Yes ◯ No
Thyroid/Parathyroid Disease	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ 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 inaccurate information can be dangerous to my (or patient's) health. It is my responsibility to inform the dentist office of any changes in medical status.

Name of patient: _____

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

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DENTAL CLINIC POLICIES

1. I acknowledge that I have received a copy of MSW's Notice of Privacy Practices
2. I understand that 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 the program.

MY SIGNATURE BELOW SHOWS THAT I HAVE READ AND UNDERSTAND ALL OF MSW'S POLICIES AND TREATMENT INFORMATION.

Name of patient: _____

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