Volunteer Supported, Grant & Donation Funded Dental Clinic
Serving Eligible Children in Green & Lafayette Counties in Wisconsin
411 22nd Avenue, Monroe, WI 53566
608-328-9404 | Fax 608-298-8246

PATIENT REGISTRATION - WELCOME!

Tell us about yourself/ child:

Patient name: _____ Preferred Name: _____ Child's Gender: M F
Last First MI

Patient Date of Birth: ____/____/_____ Age: _____ Home Phone: _____

Home Address: _____
Street City County State Zip Code

Does this patient have any **other** dental insurance? Yes / No Name of **other** insurance:_____
Has the patient had a recent cleaning or fluoride through their school/ dental office? Yes / No If yes please give date:_____
If a patient is a child what adults are with today?_____
Please provide the Member Id # on the patient/ child Forward Health card:_____

Parent/Legal Guardian Information:

Name: _____
Mother Father Guardian Foster-Parent Other
Home Address: _____
_____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
May we send email? Y N Text to phone? Y N

Other Adult Contact: _____
Mother Father Guardian Foster-Parent Other
Other Contact Address: _____
_____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
May we send email? Y N Text to phone? Y N

Signature on File (Please initial)

_____ I authorize the release of any information relating to treatment done on myself and/ or my child. I understand that and hereby authorize payment to Fowler Dental clinic from Forward Health/Badger Care/Medicaid or other medical insurance payer.

HIPAA (Health Insurance Portability and Accountability Act) (Please initial)

_____ I understand and acknowledge that I have read and understand the Notice of Privacy Practices, and that I may receive a paper copy upon request. In addition, my signature below is written permission under Wisconsin law for the use of patient medical and dental records to carry out treatment and health information.

PERMISSION/AUTHORIZATION: The permission of the parent or legal guardian is necessary for the dental treatment of a minor. The above information I have given is correct to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes. I authorize the dental staff to perform any and all necessary dental treatment that I/or my child needs.

_____ _____
Parent/Legal Guardian Signature Date

Patient Registration, Medical History and Consent Form W/Covid Screening-2021.08.09

Patient Name: Birth Date: Date Created:

Covid 19 Screening Questions

Temperatures upon arrival at Fowler Dental | Comment

Covid 19 Questions

Diagonosed w/Covid (2 wks)	◯ Yes ◯ No	Fever over 100 degrees	◯ Yes ◯ No	Chills	◯ Yes ◯ No
Severe Headache	◯ Yes ◯ No	Muscle pain or weakness	◯ Yes ◯ No	Respiratory Illness	◯ Yes ◯ No
Skin rash or irritation	◯ Yes ◯ No	Loss of taste or smell	◯ Yes ◯ No	Covid Positive Contact (2 wks)	◯ Yes ◯ No

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 medication that you may be taking, c

GENERAL PATIENT QUESTIONS

Please answer the questions below for the patient we will be seeing in our clinic today.

Any intellectual or functional development special needs or conditions?

☐ Autism	☐ Asperger Syndrome	☐ Cerebral Palsy
☐ Down Syndrome	☐ Dyslexia	☐ ADHD

Any physical conditions or special circumstances?

☐ Wheelchair Bound	☐ Walker	☐ Oxygen Tank
☐ Head or Neck Brace	☐ Tracheotomy	☐ Other

If other please explain:	◯ Yes ◯ No	If yes
Under a physician's care now?	◯ Yes ◯ No	If yes
Had a serious head, neck, jaw or mouth injury?	◯ Yes ◯ No	If yes
Been hospitalized or had a major operation recently?	◯ Yes ◯ No	If yes
Scheduled for any upcoming surgery?	◯ Yes ◯ No	If yes
Had complications from general anesthesia?	◯ Yes ◯ No	If yes
Taken any medications, pills, or drugs? (prescribed OR over the counter)	◯ Yes ◯ No	If yes
Have any allergies or reactions to any medications?	◯ Yes ◯ No	If yes
Takes, or has ever taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Takes, or has ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
On a special diet?	◯ Yes ◯ No	If yes
Uses, or has used, controlled substances?	◯ Yes ◯ No	If yes
Uses, or has used, tobacco?	◯ Yes ◯ No	
Immunizations are up to date?	◯ Yes ◯ No	

General List Questions

Women: Are you...

Pregnant/Trying to get pregnant? ◯ Yes ◯ No | Nursing? ◯ Yes ◯ No | Taking oral contraceptives? ◯ Yes ◯ No

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Acrylic
- ☐ Sulfa Drugs
- ☐ Tylenol
- ☐ Penicillin
- ☐ Metal
- ☐ Local Anesthetics
- ☐ Fluoride
- ☐ Codeine
- ☐ Latex
- ☐ Dyes
- ☐ Morphine

Other? ☐ If yes

How many times a day do you brush your teeth?

- ☐ 1 time a day
- ☐ 2-3 times a day
- ☐ Do not brush each day

Do you floss? ◯ Yes ◯ No

Do you get fluoride from your drinking water, toothpaste, vitamins or a rinse? ◯ Yes ◯ No If yes

Current Health

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No	Lymes Disease ◯ Yes ◯ No	Muscular Dystrophy ◯ Yes ◯ No	Multiple Sclerosis ◯ Yes ◯ No
Hearing Impaired-Severely ◯ Yes ◯ No	Vision Impaired-Severely ◯ Yes ◯ No	Parkinson Disease ◯ Yes ◯ No	COPD ◯ Yes ◯ No

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

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Photo Permission Form

Photographs may be taken at any event. Please complete the following form for yourself and your minor child. If you do not want photos taken at a group event, please let us know and we will give you a special indicator/sticker to wear to ensure we do not include you or your child in published photographs.

Events are held at Fowler Dental Clinic and Fowler Dental Clinic outreach events at off site locations.

I hereby grant permission to the FOWLER DENTAL CLINIC (FDC) (collectively, the "organizations" and individually, an "organization"), to take photographs and/or digital images of myself and my minor child(ren) listed below.

I hereby authorize the organizations to use, reuse, reproduce, publish, or republish any photographs, recordings, or any other record of my and my child's participation in this event, in any medium now known or hereafter developed, alone or in conjunction with other material, without restriction as to changes or alterations, as well as to use my child's name, voice, likeness, and/or other indicia of identity, for editorial, educational, promotional, or advertising purposes, including without limitation in connection with the solicitation of contributions and the furtherance of the objectives of the organizations and Give Kids A Smile program

I authorize use of the images without compensation to me. All negatives, prints, digital reproductions shall be the property of the organization taking the image.

_____

Name(s) of Child Covered by this Release (please print)

_____

Name of Parent/Guardian (please print)

_____

Address of Parent/Guardian

_____

Signature of Parent/Guardian

_____

Date

W:\Shared Docs (SERVER)\Forms\Consents\Image Release drafts\2019 Photo Release.docx

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Broken Appointment Policy

Welcome to our clinic! We want to thank you for choosing us as your dental health provider. In order to give you the best possible care we request that you review our policy regarding broken appointments.

What is a broken appointment?

An appointment is considered broken due to any of the following:

1. The patient doesn't come to the appointment.
2. The patient is more than 15 minutes late for the appointment.
3. The patient cancels with less than 24 hours notice.

What happens if you break an appointment?

It is our policy not to accept patients who do not show for their **first scheduled appointment**.

An established patient family that breaks more than **3 appointments within 1 year** will be allowed to make appointments for care on same day as our schedule allows. Alternatively, you may be dismissed from our practice and need to establish care with another dental office.

If more than 2 children in a family missed their appointments on the same day, we will not be able to schedule the whole family together in the future.

Are there any exceptions to these rules?

There may be exceptions to our broken appointment policy to our discretion. **The best thing to do is to keep our staff informed.** Please give us a call 24 hours in advance, or as soon as you discover the need to change an appointment. If your family misses an appointment, call us within a day to reschedule.

If you are an established family with our practice and are dismissed, Fowler Dental Clinic, by law, will be available to handle emergencies only for 30 days starting from the date of our dismissal letter. This will allow you time to find a new dentist to care for your children.

Please Note:

As a courtesy we make every attempt through phone calls to remind you of upcoming visits. If your address or phone number changes please update us so that you can continue to receive our reminders. Please remember that you, as the responsible party, are ultimately responsible for your child's appointment(s) and as such we respectfully ask that you take a moment to record appointments on your calendar or in your phone.

I have read and understand the broken appointment policy stated above:

Child's Name:_____ DOB:_____

Guardian Signature:_____ Date:_____

Printed Guardian Name:_____

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Consent to Treat Patient without Parent/Legal Guardian Present Authorization

I have the legal right to preauthorize *Fowler Dental Clinic* and its personnel to deliver dental treatment and services to my child. Dental care may include, but is not limited to: dental examinations, prophylaxis (cleaning), fluoride treatments, x-rays, fillings, crowns, dental pulpotomy, spacers, extractions and/or any other treatment deemed necessary.

I_____(print parent/legal guardian name) request and authorize *Fowler Dental Clinic* and its personnel to deliver dental care to my child listed below as deemed necessary in the diagnosis and/or treatment of the minor child.

Child's Name: _____ **DOB:**_____
Allergies or Current Medications:_____
_____

LIMITATIONS
Identify any specific limitations on the kinds of dental services/treatment for which this authorization is given. If none, please state "NONE":_____

Parent/Legal Guardian Contact Information For Questions <u>DURING THE APPOINTMENT TIME</u>

Parent/Legal Guardian Name:_____
Contact Phone # _____Alternate Phone #:_____
Relationship to minor (circle one): Parent / Legal Guardian

I hereby authorize the below listed individuals to bring my child to his/her appointments if I am unable to attend. I understand that medical/dental advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice or when a minor becomes the age of 18 and that a photocopy of this form is considered valid as the original.

Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

Print Name:_____
Signature:_____Date:_____