

Tri-County Community Dental Clinic Minor Registration Form

(All information must be completed by the minor patient parent or guardian who is accompanying the patient)

Patient Name: _____

Street Address: _____

City: _____ Zip: _____ County: Calumet/Outagamie/Winnebago

Phone: Home (920) _____ - _____ Work (920) _____ - _____ Cell (920) _____ - _____

Male/Female _____ Birth date _____/_____/_____

SSN _____ - _____ - _____ Insurance: _____

BadgerCare/Medicaid/Other _____

Race/Ethnicity – (circle only one)

White/Non Hispanic Asian Black/African American Hispanic/Latino
American Indian/Alaskan Hawaiian/Pacific Islander Other

Parent/Guardian Information

Name: _____

Address _____

(If different than patient address)

Relationship to patient: _____

PLEASE INITIAL AND DATE EACH ITEM BELOW

1. I certify that the above information stated is true. I authorize TCCDC to verify all household income. This information will only be used as documentation and will be kept confidential and in a secure location.
Initial _____ Date _____
2. I have read the private practices (HIPPA) notices.
Initial _____ Date _____
3. I acknowledge and agree to dental service/treatments that may be provided by a Marquette University School of Dentistry dental student or a Fox Valley Technical College hygiene student supervised by a licensed dentist.
Initial _____ Date _____

4. I understand that all children under 18, including those in waiting room, must be supervised by a legal guardian at every visit. Children accompanying patients receiving treatment are not allowed in the treatment room.
Initial _____ Date _____
5. I understand co-pays are required at every appointment and may only be paid in cash.
Initial _____ Date _____
6. I understand if I fail to show for an appointment with out canceling in advance, that I will not be able to make another appointment for 6 months. In the incident of an emergency, TCCDC will waive the no show for the one time with a fee of \$25.00 plus co-pay.
Initial _____ Date _____
7. TCCDC may take pictures to use in their public relations. I give TCCDC permission to use pictures of the patient in any future publications regarding the clinic.
Initial _____ Date _____

Services

1. Emergency care--swelling, infection, pain, etc. (Emergencies are seen in between scheduled appointments)
2. Routine exams, cleanings, sealants, and fillings for children ages 3-18.
3. Education on preventative care
4. We do **NOT** do dentures, bridges, partials, crowns, or braces.
5. We do **NOT** do molar root canals on adults.
6. We do **NOT** treat TMJ.
7. We do **NOT** provide oral or IV sedation.
8. We do **NOT** provide the replacement of the extracted teeth with a denture or a bridge. Should you agree to have all your teeth removed for dentures, this will only be done **after** you have a scheduled appointment with a dentist to fit you for dentures.

Treatment Options

The student or volunteer will inform you of a treatment plan(s) that is in best interest of your dental and medical health. You may choose to have the procedure done at the Clinic or you may decide to have it done elsewhere or not at all.

Please sign

I have read and understand both sides of TCCDC’s registration form. By signing below I agree to all conditions stated.

Name of patient _____

Signature _____ Date _____

----- **Office Use Only** -----

Income \$ _____ # _____ Co-pay \$ _____ Forward card verified Y/N # _____

Last Verification Date: _____ by: _____