Tri-County Dental Clinic
Adult's Registration Form

Patient Name:____ Date______________________

Address:________________________________ City:_______________State:_____ Zip:___________

County: Calumet/Outagamie/Winnebago/Other

Phone: Home ( ) ______-_________ Work ( )______-__________ Cell ( )_______-__________

Male/Female Birth date______/______/______ Email:______________________________________

Medicaid/Dental Insurance: _____________________________

Race/Ethnicity –

White/Non Hispanic Asian Black/African American Hispanic/Latino

American Indian/Alaskan Hawaiian/Pacific Islander Other

PLEASE INITIAL EACH ITEM BELOW

1. I certify that the above information stated is true. I authorize TCD to verify all household income. This information will only be used as documentation and will be kept confidential and in a secure location.
   Initial _____

2. I have read the Notice of Privacy Practices (HIPAA).
   Initial _____

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 _____

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 _____

5. I understand co-pays are required at every appointment and may be paid in cash or by credit card.
   Initial _____

6. TCD may take pictures to use in their public relations. I give TCD permission to use pictures of myself in any future publications regarding the clinic.
   Initial _____

7. TCD has my permission to release my dental records such as x-rays and clinical notes for either personal use or change of dental provider.
   Initial ______

OVER---->

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. We do **NOT** do dentures, bridges, partials.
4. We do **NOT** treat TMJ.
5. We do **NOT** provide oral or IV sedation.
6. 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.

Cancellation/ No Show Policy

1st time: Patient will not be able to make an appointment for 6 months but will be allowed to use the walk in services with a double copay expected at time of visit.

2nd time: Patient will need to provide a written explanation to the clinic director on why they missed their appointment and why they should be allowed back to TCD. **No appointments** will be made until the letter is reviewed and ok'd. The patient will have one opportunity to use the walk in services once a letter is written. If a letter is not received within 3 months of the missed appointment, the patient will be **terminated.**

3rd time: Patient will be **terminated** at TCD. Patient will **not** be allowed to use walk in services.

Same day cancellations will be treated as a no show.

Please sign and date

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

Signature: ____ Date: ________________