Tri-County Dental Clinic
Children's Registration Form

(All information must be completed by the patient's parent or guardian)

Patient Name:_____Date:_____

Street Address:_____City:_____State:_____ Zip:_____

County: Calumet/Outagamie/Winnebago/Other

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

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 AND DATE 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 parents and/or guardians **will not** be allowed in the treatment room for routine care.
   Initial _____

5. I understand if I fail to show for an appointment without canceling in advance for my children, that I will not be able to schedule any future family appointments.
   Initial _____

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

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

OVER--->

If I am unable to attend the appointment with my child, the following people may accompany them and make decisions in my absence

Name: _____Relationship to Child: _____

Name: _____Relationship to Child:_____

- **Responsible parties can fill out forms and receive medical and dental information pertaining to visit.**
- **Patient is 15 years old or older and can attend appointments without my presence.**

Medical Treatment Consent for Minors

Dear Parent or Guardian:

I hereby authorize the treatment, administration of anesthesia, and surgical treatment(s) for my minor child: In the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. The authorization extends to any hospital or physician office and both physician and assisting personnel with the hospitals or physicians office(s) as well as any physician office, medical authorities and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary to my minor child. **This form is only valid for one year from the date signed.**

_____

Printed Name of Parent or Legal Guardian **Signature** **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. We do **NOT** do dentures, bridges or 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.

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.

Name of patient_____ Relationship to Patient _____

Signature_____ Date_____