Lake Area Free Clinic

Dental Patient Registration

General Information

Legal Full Name: Gender: M F

Social Security #: Date of Birth (MM/DD/YYYY):

Self-reported race: Caucasian/White African American/Black Hispanic/Latino(a)
American Indian/Alaskan Native Native Hawaiian/Pacific Islander Other:

Marital Status: Divorced Live with Significant Other Married (Name of Spouse):
Never Married Separated Widowed

Cell Phone #: Home/Secondary Phone #:

Email Address:

Street Address:

City, State, Zip Code: County:

Have you visited the emergency room for DENTAL PAIN? If so, list date:

Primary Language: Secondary Language:

Can you read in your primary language?: Yes No Can you read in your secondary language?: Yes No

Would you like an interpreter at your appointments?: Yes – Language?: No

Emergency Contact Information

Name of Emergency Contact: Emergency Contact Phone #:

Referral Information

How did you hear about LAFC – Dental Clinic?

LAFC Medical Clinic Dental Office Hospital – Emergency Room Urgent Care
□ Medical Provider Newspaper Friend Social Services
Website Insurance Provider Word of Mouth Church
Food Pantry Waukesha County Community Dental Clinic Other:

Payment Information

How do you pay for your dental care (check all that apply)?

BadgerCare/Forward Health/Medicaid Self-pay/Debt Other:_____

Employment and Income Information

Are you currently working? Yes –Where? No

If working, do you work: Full Time Part Time Seasonal Other:

List all members of your **TAX HOUSEHOLD** (**anyone included on your Federal taxes:** spouse, children, dependents):

Full Name	Relationship	Date of Birth/Age

Total number of individuals in your tax household(including yourself):_____

Please check **all** income sources for **all** members of your **TAX HOUSEHOLD** & provide amount per month:

Alimony - $_____ Interest/Dividends (Taxable Investment Income) - $_____

Rental Income (Land Owner/Landlord) - $_____ Pension (Taxable Retirement Income) - $_____

Social Security Disability - $_____ Social Security Retirement - $_____

Tribal Per Capita Payments - $_____ Unemployment Compensation - $_____

Wages From Employment - $_____ Other- $_____

What is your current **monthly** TAX HOUSEHOLD income?	What is your expected **yearly** TAX HOUSEHOLD income?

Did you file Federal Income Tax **last year**? Yes No – Why not?

LAFC – Dental Clinic Policies:

1. Patients that do NOT cancel an appointment with at least 24 hours notice will be considered a MISSED appointment.
2. Patients that arrive more then 10 minutes late for an appointment will NOT be seen and considered a MISSED appointment.
3. Patients will be responsible to call LAFC with phone number changes. If a phone is disconnected and you miss an appointment it will be considered a MISSED appointment.
4. Patients must call back to confirm appointments by **noon the day proir to their apppointment**, or the appointment will be canceled and given to another patient.
5. **ONE MISSED** appointment in a 12 month period **WILL RESULT IN YOU NOT BEING SEEN AT THE CLINIC FOR 12 MONTHS.** You will be seen on an emergency basis only.
6. I understand **Co-pays must be paid at the time of the appointment with CASH ONLY.** If you cannot pay for your appointment notify the clinic at least 24 hours in advance.
7. I agree to services provided by WCTC dental hygiene and assistant students under the supervision of a licensed provider.

I certify that all the information on the LAFC Patient Application is accurate to the best of my knowledge. If I experience any changes to residency, income and/or insurance I will notify the LAFC. I understand and agree to the policies and treatment of the LAFC – Dental Clinic.

Patient Signature: _____ Date: _____