Information About More Smiles WI Dental Clinic Located Inside BGC

Clinic hours are from 8-5 Monday through Thursday
There will be clinics held on some Saturdays, dates will vary
We will also be offering Friday clinics (dates to be determined)

The clinic will see patients of all ages and can provide a full array of dental services including exams and x-rays, extractions, fillings, cleanings, sealants, and dentures/partials.

We do not offer implants veneers, impacted wisdom teeth extractions or orthodontics such as braces.

The clinic accepts anyone who is under 200% of the Federal Poverty level. We accept most Medicaid Plans and serve uninsured patients on a reduced fee private pay scale. We do not accept patients who have private dental insurance (for example, Delta Dental). Below is both the income guidelines chart and the private pay fee scale for uninsured patients.

Appointments can be scheduled by calling **(608) 665-2752**. All appointments must be scheduled, the clinic does not accommodate walk-ins.

Federal Poverty Level (FPL) Income Guidelines

Family Size	100% FPL	101-125%	126-150%	151-175%	176-200%
1	$1,005.00	$1,256.25	$1,507.50	$1,758.75	$2,010.00
2	$1,353.33	$1,691.66	$2,030.00	$2,368.33	$2,706.66
3	$1,701.67	$2,127.09	$2,552.51	$2,977.92	$3,403.34
4	$2,050.00	$2,562.50	$3,075.00	$3,587.50	$4,100.00
5	$2,398.33	$2,997.91	$3,597.50	$4,197.08	$4,796.66
6	$2,746.67	$3,433.34	$4,120.01	$4,806.67	$5,493.34

Private Pay Fee Scale

Appointment Type	0-100% FPL	101-125% FPL		126-150% FPL	151-175% FPL	176-200% FPL
Emergency	$20/visit	$30/visit		$40/visit	$50/visit	$60/visit
Extraction	$40/tooth	$60/tooth		$80/tooth	$90/tooth	$100/tooth
Comp Exam	$10/visit	$15/visit		$20/visit	$30/visit	$40/visit
Restorative	$50/tooth	$75/tooth		$100/tooth	$125/tooth	$150/tooth
Dentures (Lab fees vary $200-$600)	Lab Fee*1.5	Lab Fee*1.5		Lab Fee*1.5	Lab Fee*1.5	Lab Fee*1.5
Hygiene	$30	$30	$35	$40	$45	$50

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BOYS & GIRLS CLUB
OF DANE COUNTY

Child Health/Dental History Form

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Child's Name _____ Date of Birth _____
LAST FIRST M.I. (##/##/###)

Sex: M ☐ F ☐ Nickname _____ Height _____ Weight _____

Parent/Guardian Name _____ Relationship to child _____

Name of Physician _____ Phone _____

Is the child being treated by a physician at this time for anything specific? If yes, what? _____

Has the child had any history of, or conditions related to, any of the following:

☐ADD/ADHD	☐Chicken Pox	☐Growth Problems	☐Kidney	☐Rheumatic Fever	☐Thyroid
☐Anemia	☐Chronic Sinusitis	☐Headaches	☐Lactose	☐Scarlet Fever	☐Tobacco/Drug use
☐Arthritis	☐Cysitc Fibrosis	☐Hearing	☐Liver	☐Scoliosis	☐Tobacco exposure
☐Asthma	☐Diabetes	☐Heart Defect	☐Measles	☐Seizures	☐Tonsils
☐Autism	☐Dizziness	☐Hepatitis	☐Migraines	☐Sickle Cell	☐Tuberculosis
☐Bladder	☐Ear Aches	☐Blood Pressure	☐Mononucleosis	☐Sleep Apnea	☐Venereal Disease
☐Bleeding Disorders	☐Epilepsy	☐HIV+/AIDS	☐Mouth breathing	☐Snoring	☐Wheezing
☐Bones/Joints	☐Excessive gagging	☐Glycemia	☐Mumps	☐Speech	☐Other_____
☐Cancer	☐Fainting	☐Immunizations	☐Pregnancy (teens)	☐STD's	
☐Cerebral Palsy	☐Frequent Cough	☐Vision	☐Rash/Hives	☐Stomach/Intestines	

Please provide details here: _____

Child's History

Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... Y ☐ N ☐

If yes, please list (w/dosage): _____

Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? ..... Y ☐ N ☐

If yes, please explain: _____

Is the child allergic to anything else, such as latex, certain foods, metals, acrylic, dyes, etc.? ..... Y ☐ N ☐

If yes, please explain: _____

How would you describe the child's eating habits? _____

Has the child ever had a serious illness? ..... Y ☐ N ☐

If yes, when? _____ Please describe _____

Has the child ever been hospitalized? ..... Y ☐ N ☐

Does the child have a history of any other illnesses? ..... Y ☐ N ☐

If yes, please list: _____

Has the child ever received a general anesthetic? ..... Y ☐ N ☐

If yes, any problems? _____

Does the child have any inherited problems? ..... Y ☐ N ☐

Does the child have any speech difficulties? ..... Y ☐ N ☐

Is the child up to date on immunizations against childhood diseases? ..... Y ☐ N ☐

Health History Continued on Back of Page

Child's History Continued

Has the child ever had a blood transfusion? ..... Y ☐ N ☐

Is the child physically, mentally, or emotionally impaired? ..... Y ☐ N ☐

Does the child experience excessive bleeding when cut? ..... Y ☐ N ☐

Has the child experienced abuse (physical, psychological, emotional, or sexual)? ..... Y ☐ N ☐

Is this the child's first visit to a dentist? ..... Y ☐ N ☐

If no, what was the date of last dentist visit? _____

Has the child had any problems with dental treatment in the past? ..... Y ☐ N ☐

Has the child ever had dental radiographs taken (x-rays)? ..... Y ☐ N ☐

Has the child ever had any problems with the eruption or shedding of teeth? ..... Y ☐ N ☐

Has the child ever had any orthodontic treatment? ..... Y ☐ N ☐

What type of water does the child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water

Does the child take fluoride supplements? ..... Y ☐ N ☐

Is fluoride toothpaste used? ..... Y ☐ N ☐

Dos the child participate in active recreational activities? ..... Y ☐ N ☐

How many times are the child's teeth brushed per day? _____ Does he/she floss? ..... Y ☐ N ☐

Does your child have a history of or are they currently experiencing any of the following:

☐Mouth sores or fever blisters
☐Bad breath
☐Bleeding gums
☐Sucking habit after one year of age
If yes, which: ☐Finger ☐Thumb ☐Pacifier ☐Other
For how long? _____
☐Injury to teeth, mouth, or jaws
☐Tooth ache
☐Clinching/grinding his/her teeth
☐Cavities/decayed teeth
☐Jaw joint problems (popping, etc.)

How often does your child have the following?

Candy or other sweets	☐Rarely	☐1-2 times/day	☐3 or more times/day	Product _____
Chewing gum	☐Rarely	☐1-2 times/day	☐3 or more times/day	Type _____
Snacks between meals	☐Rarely	☐1-2 times/day	☐3 or more times/day	Usual snack _____
Soft drinks*	☐Rarely	☐1-2 times/day	☐3 or more times/day	Product _____

(*such as juice, fruit flavored drinks, colas, carbonated beverages, sports or energy drinks)

What is your main concern about your child's oral health? _____

I certify that I have read and understand the above questionnaire. I acknowledge that my questions, if any, about the information requested above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

Parent's/Guardian's Signature _____ **Date** _____

For completion by Dentist—comments

_____

_____

_____

For Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

More Smiles Wisconsin Dental Clinic Application

Patient Information

Last:_____ First:_____ MI:____

Gender: ☐ Male ☐ Female Social Security Number (SSN): ____-____-_____

Street Address:_____ City:_____ Zip:_____
Phone Number: (cell)_____ (home or other):_____

Date of Birth:____/____/_____ Date of last dental visit (month/year):____/_____

Emergency Contact Name: _____

Relationship to you:_____

Emergency Contact Phone Number:_____

Dental Insurance Status: ☐ Badgercare (Forward Health Card) ☐ No Dental Insurance

Housing Status: ☐ Own ☐ Rent ☐ Family/Friends ☐ Homeless ☐ Other:_____

Marital Status: ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐ Domestic Partnership ☐ Single

Race/Ethnic Group:

☐ American Indian or Alaskan Native
☐ Asian or Pacific Islander
☐ Black or African American
☐ Hispanic
☐ White/Caucasion
☐ Hmong
☐ Other:_____

Employment Status:

☐ Employed full-time
☐ Empoyed part-time
☐ Unemployed
☐ Retired
☐ Receiving SSI/Disability

Are you a veteran? ☐ Yes ☐ No

Parent/Guardian information for child under age 18 (if applicable):

Name of parent/guardian:_____

Relationship to child:_____

How did you hear about us?

☐ Internet ☐ Access ☐ Friend/Family ☐ Dane Cares ☐ Salvation Army ☐ United Way/211
☐ Dean ER ☐ UW ER ☐ Medic ☐ Badgercare ☐ Other (specify):_____

I hereby authorize More Smiles Wisconsin's Dentists and their team to perform upon myself dental procedures which may include the use of anesthetic and surgical equipment. I understand that if I have questions or concerns, I can express them to the Dentist before the procedure is performed and he/she will talk with me about the risks and benefits of the procedure and any alternatives that may exist. My signature on this form certifies that I authorize More Smiles Wisconsin to use the above information for its end of year demographic analysis and also certifies that I have received a copy of More Smiles Wisconsin's Notice of Privacy Practices.

Signature of patient or guardian:_____ Date:____/____/_____

For office use:
Check box to indicate info has been entered ☐ Initial here: _____ Date: _____