St. Vincent de Paul Dental Clinic

Clinic Location:
1906 North Street
Prairie du Sac, WI 53578
Phone (608) 644-0504 ext. 10
stvdpdental@gmail.com

Application Guidelines

Purpose: The purpose of the St. Vincent de Paul Dental Discount Program is to provide discounted dental services to qualified uninsured/underinsured clients.

Definitions:

- Household includes anyone who resides with you.
- Gross Income: Income is calculated based on Gross Income (money earned before deductions, such as taxes), Household money received through employment, SSDI, SSI, Unemployment, Child Support, Pension, Disability or Social Security.

Procedure:

- Due to cost of postage, applications will not be mailed. They will be available at the St. Vincent de Paul Resource Center and the Sauk & Columbia County Human Services buildings.
- Patient Registration application **MUST** be completed, signed, and returned prior to a scheduled appointment.

Verifications Required/Purpose of Verifications:

Verification Needed	Purpose	Acceptable Documentation
Income	Verify Earnings so we can place you correctly on the sliding scale	**(One from this group if you don't have any insurance)** • Pay stubs (last 2 pay periods) • Recent Tax filing • Food Stamps • Statement stating "no income" • Letter from employer • "13.7263.3 Earnings Verification" form • Unemployment earnings • SSI/SSDI income information
ID	Verify Identity	**(One from this group)** • Driver's License • School ID • State Issued ID • Passport • Green Card • SSN
Proof of Dependents	Verify Responsibility of Children	**(One from this group if you don't have any insurance)** • Copy of Birth Certificate • "Footprints" from hospital • School Enrollment Form • Taxes with Children Listed as Dependents
Partnership	Verify Number of People in Household	**(One from this group if you don't have any insurance)** • Marriage License • Bank Statements • Lease/Mortgage with Both Names Listed
Proof of Residency	Verify Residence	**(One from this group)** • Recent Utility Bill • Rental Lease

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Patient Registration

County _____

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial _____
Address _____ Address 2 _____
City, State, Zip _____
Home Phone _____ Work Phone _____ Cellular _____ Ext _____
Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth Date _____ Age _____ Social Security _____ Drivers Lic _____
Email _____

SECTION 2

Employment Status ☐ Full Time ☐ Part Time ☐ Retired
Student Status ☐ Full Time ☐ Part Time
Medicaid ID _____
Badger Care ID _____

SECTION 3

Driver's License # _____
Spouse's Name _____
Emergency Name _____
Emergency Phone Number _____
Number of People in Household _____

RESPONSIBLE PARTY

First Name _____ Last Name _____ Middle Initial _____
Address _____ Address 2 _____
City, State, Zip _____
Home Phone _____ Work Phone _____ Cellular _____
Birth Date _____ Social Security _____ Drivers Lic _____ Ext _____
☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Soc Sec _____ Insured Birth Date _____
Employer _____ Insurance Company _____
Address _____ Address _____
Address 2 _____ Address 2 _____
City, State, Zip _____ City, State, Zip _____
Rem Benefits _____ Rem Deduction _____

Medical History

Patient Name _____

Birth Date _____ Date of Last Dental Exam _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes O No	If yes, please explain _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes, please explain _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes, please explain _____
Are you taking any medications, pills, or drugs?	O Yes O No	If yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	_____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	O Yes O No	_____
Are you on a special diet?	O Yes O No	_____
Do you use tobacco?	O Yes O No	_____
Do you use controlled substances?	O Yes O No	_____

WOMEN ARE YOU:

Pregnant/Trying to get pregnant? O Yes O No Taking Oral Contraceptives? O Yes O No Nursing? O Yes O No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

AIDS/HIV Positive	OY ON	Cortisone Medicine	OY ON	Hemophilia	OY ON	Radiation Treatments	OY ON
Alzheimer's Disease	OY ON	Diabetes	OY ON	Hepatitis A	OY ON	Recent Weight Loss	OY ON
Anaphylaxis	OY ON	Drug Addiction	OY ON	Hepatitis B or C	OY ON	Renal Dialysis	OY ON
Anemia	OY ON	Easily Winded	OY ON	Herpes	OY ON	Rheumatic Fever	OY ON
Angina	OY ON	Emphysema	OY ON	High Blood Pressure	OY ON	Rheumatism	OY ON
Arthritis/Gout	OY ON	Epilepsy or Seizures	OY ON	High Cholesterol	OY ON	Scarlet Fever	OY ON
Artificial Heart Valve	OY ON	Excessive Bleeding	OY ON	Hives or Rash	OY ON	Shingles	OY ON
Artificial Joint	OY ON	Excessive Thirst	OY ON	Hypoglycemia	OY ON	Sickle Cell Disease	OY ON
Asthma	OY ON	Fainting Spells/Dizziness	OY ON	Irregular Heartbeat	OY ON	Sinus Trouble	OY ON
Blood Disease	OY ON	Frequent Cough	OY ON	Kidney Problems	OY ON	Spina Bifida	OY ON
Blood Transfusion	OY ON	Frequent Diarrhea	OY ON	Leukemia	OY ON	Stomach/Intestinal Disease	OY ON
Breathing Problem	OY ON	Frequent Headaches	OY ON	Liver Disease	OY ON	Stroke	OY ON
Bruise Easily	OY ON	Genital Herpes	OY ON	Low Blood Pressure	OY ON	Swelling of Limbs	OY ON
Cancer	OY ON	Glaucoma	OY ON	Lung Disease	OY ON	Thyroid Disease	OY ON
Chemotherapy	OY ON	Hay Fever	OY ON	Mitral Valve Prolapse	OY ON	Tonsillitis	OY ON
Chest Pains	OY ON	Heart Attack/Failure	OY ON	Osteoporosis	OY ON	Tuberculosis	OY ON
Cold Sores/Fever Blisters	OY ON	Heart Murmur	OY ON	Pain in Jaw Joints	OY ON	Tumors or Growths	OY ON
Congenital Heart Disorder	OY ON	Heart Pacemaker	OY ON	Parathyroid Disease	OY ON	Ulcer	OY ON
Convulsions	OY ON	Heart Trouble/Disease	OY ON	Psychiatric Care	OY ON	Venereal Disease	OY ON
						Yellow Jaundice	OY ON

Have you ever had any serious illness not listed above? OY ON

If yes, please explain _____

Do you use any pre-medications? OY ON

If yes, please list antibiotic used. _____

ALWAYS CHECK WITH YOUR FAMILY DOCTOR BEFORE YOUR DENTAL APPOINTMENT TO SEE IF YOU NEED TO BE PRE-MEDICATED OR IF YOU NEED TO STOP TAKING ANY MEDICATIONS!

Signature _____ Date _____

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Financial Assistance Worksheet

Name _____ **Date** _____

INCOME	SELF—MONTHLY	SPOUSE/HOUSEHOLD—MONTHLY
Employment/Wages		
Unemployment		
Disability/SSI		
Food Stamps		
Child Support		
Other		
TOTAL		