ST. VINCENT DE PAUL DENTAL CLINIC

Office Location:
815 19th Street
Prairie du Sac, WI 53578
Phone/Fax: (608) 643-8905
Email: stvdpmanager@frontier.com

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

Application Guideline

Purpose: The purpose of the St. Vincent de Paul Dental Discount Program is to provide discounted dental services to qualified uninsured/under insured 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. There are NO EXCEPTIONS. They will be available at the St. Vincent de Paul Resource Center.
- Patient registration application must be application must be completed, signed and returned prior to scheduled appointment.
- All clients will be interviewed and approved by a St. Vincent Dental Clinic Representative based on Federal Poverty Level (FPL) guidelines according to income and family size.

Verifications Required/Purpose of Verifications:

Verification Needed	Purpose	Acceptable Documentation
Income	Verify earnings	(Two forms from this group) • Pay stubs (last 2 pay periods) • Recent Utility bill • Recent Tax filing • Statement stating 'no income' • Letter from employer • 'Earnings Verification' form • Unemployment earnings • SSI/SSDI income information
ID	Verify identity	• Driver's License • School ID • State issued ID • Passport • Green Card
Proof of Dependents	Verify responsibility of Children	• Copy of Birth Certificate • 'Footprints' from hospital • School Enrollment form • Taxes with children listed as dependents
Partnership	Verify number of People in household	• Marriage License • Bank statements • Lease/Mortgage with both names listed

Date _____

ST. VINCENT DE PAUL DENTAL CLINIC
1906 NORTH STREET
PRAIRIE DU SAC, WI 53578
(608) 644-0504 – EX. 10 or 12

PATIENT REGISTRATION

ID: _____ Chart ID: _____
First Name: _____ Last Name: _____ Middle Initial: _____
Patient is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party
Responsible Party (is someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____

City, State, Zip: _____ Cellular: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder

Patient Information
First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____ Cellular: _____
Home Phone: _____ Work Phone: _____ Ext: _____
Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed
Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____
Email: _____

---------- Section 2 ---------- Section 3 ----------

Employment Status: ○ Full Time ○ Part Time ○ Retired
Student Status: ○ Full Time ○ Part Time
Medicaid ID: _____ Badger Care ID # _____
Employer ID: _____
Carrier ID: _____

Driver's license #: _____
Spouse's name: _____
Emergency name & #: _____
Date of Last Dental Exam _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Sources of Income *(Monthly): Mark all that apply.*

Employment	$ _____	*Other Support:*	
Self-Employment	$ _____	Housing Rent Assistance ☐	$ _____
Unemployment	$_____	Fuel Assistance ☐	$_____
Workers Compensation	$_____	Food Pantry ☐	$_____
Child Support	$_____	Food Stamps ☐	$_____
S.S.I.	$_____	Medical Assistance ☐	$_____
Pension	$_____	Energy Assistance ☐	$_____
Disability	$_____		

Household Monthly Income: _____
(Include the salary of all working members of the household in total monthly income.)

Date _____

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, you 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? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ 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 ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problem ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No _____

Comments:

_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to y (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

St. Vincent de Paul Dental Financial Assistance Worksheet

Name _____ Date _____

INCOME	Self-Monthly	Spouse/Household/Monthly
Employment/Wages		
Unemployment		
Disability/SSI		
Food Stamps		
Child Support		
Other		
TOTAL		
Monthly Expenses	**Self/Monthly Payments**	**Household/Outstanding Bills**
Rent or Mortgage		
Lot Rent		
Utilities (water & light)		
Heat (gas or fuel oil)		
Phone Bill		
Food & Misc Hygiene		
Vehicle Payment		
Home owners Insurance/Car Insurance		
Gasoline		
Health Insurance		
Credit Card Payments		
Medication Expenses		
Clinic/Hospital Bills		
Alimony/Child Support		
Storage Unit		
Cigarettes/Alcohol		
Cable/Satellite/Internet/Direct TV		
Other Expense		
Total	**Total**	