St. Vincent de Paul Dental Clinic

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

Clinic Location:
1906 North Street
Prairie du Sac, WI 53578
Phone (608) 644-0504 ext 10
svdpcrc@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. There are **NO EXCEPTIONS**. They will be available at the St. Vincent de Paul Resource Center.
- Patient Registration application must be completed, signed, and returned prior to a 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 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	• Driver’s License • School ID • State Issued ID • Passport • Green Card • SSN
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
Proof of Residency	Verify Residence	• Recent Utility Bill • Rental Lease

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Patient Registration

ID _____ Chart ID _____

RESPONSIBLE PARTY

First Name _____ Last Name _____ Middle Initial _____

Address _____ Address 2 _____

City, State, Zip _____ Cellular _____

Home Phone _____ Work Phone _____ Ext _____

Birth Date _____ Social Security _____ Drivers Lic _____

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

PATIENT INFORMATION

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 _____ 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

Employer ID

Carrier ID

SECTION 3

Driver's License # _____

Spouse's Name _____

Emergency Name _____

Emergency Phone Number _____

Date of Last Dental Exam _____

Number of People in Household _____

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 _____

SOURCES OF INCOME (MONTHLY) MARK ALL THAT APPLY

Employment $ _____

Self-Employment $ _____

Unemployment $ _____

Workers Compensation $ _____

Child Support $ _____

Social Security $ _____

SSI $ _____

OTHER SUPPORT

Housing Rent Assistance ☐ $ _____

Fuel Assistance ☐ $ _____

Food Pantry ☐ $ _____

Food Stamps ☐ $ _____

Medical Assistance ☐ $ _____

Energy Assistance ☐ $ _____

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Pension	$ _____	Household Monthly Income _____$
Disability	$ _____	(Include the salary of all working members of the household)

Medical History

Patient Name _____ Birth Date _____

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 Fsamax, 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?

☐ Asprin ☐ 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	Hemophilis	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	Rehumatism	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	Ulcera	OY ON
Convulsions	OY ON	Heart Trouble/Disease	OY ON	Psychiatric Care	OY ON	Veneral Disease	OY ON
Have you ever had any serious illness not listed above?			OY ON			Yellow Jaundice	OY ON

_____

COMMENTS _____

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!

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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 my (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_____

Financial Assistance Worksheet

Name_____ Date _____

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

EXPENSES	SELF—MONTHLY	SPOUSE/HOUSEHOLD—MONTHLY
Rent or Mortgage		
Lot Rent		
Utilities (water & light)		
Heat (gas or fuel oil)		
Phone Bill		
Food & Misc Hygiene		
Vehicle Payment		
Homeowner's/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		

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TOTAL		