

**Northeast Wisconsin Technical College
Dental Clinic
Patient Registration**

PATIENT INFORMATION

Name: Last	First	MI	Date of Birth:	Forward Health ID Number:	
Address:			City:	State:	Zip Code:
County:			Home Phone:	Work Phone:	Cell Phone:

PARENT/GUARDIAN INFORMATION

Name of Financially Responsible Party:	Relationship to Patient:	Phone Number:
Address(if different from above)	City:	State and Zip Code:

METHOD OF PAYMENT: (circle one)

Medical Assistance

CASH

Debit/Credit

Northeast Wisconsin Technical College Dental Clinic asks that you voluntarily respond to the following questions. The demographic information will be used to collect data for grants and funding.

Gender:

_____ Male

_____ Female

Race/ethnicity:

_____ Black

_____ American Indian or Alaskan Native

_____ Hispanic

_____ Asian or Pacific Islander

_____ White (not of Hispanic origin)

Employment Status:

_____ Unemployed

_____ Employed Part-time

_____ Employed Full-time

_____ Student

_____ Retired

_____ Other _____

Annual Household Income:

_____ under \$10,000

_____ \$11,000 – 25,000

_____ \$26,000 – 35,000

_____ \$36,000 – 45,000

_____ \$46,000 – 55,000

_____ \$56,000 and above

Briefly describe your need for dental services:
