Knox County Health Clinic
22 White St., Rockland, ME 04841
Phone 594-6996 Fax 594-6995
info@knoxclinic.org www.knoxclinic.org

Adult Dental Program Application

Please complete this application and return it *with proof of income and appropriate fee* to 22 White St. Rockland, ME 04841

Do I qualify for Dental Clinic services?

Yes, if my family's earnings are at or below 200% of federal poverty guidelines (included on page 5), I am under 55 years of age, and I fit one of the following categories:

- I am currently employed
- I am actively seeking employment
- I am in school
- I am a stay-at-home parent

Do I qualify for Denture services?

Yes, if my family's earnings are at or below 200% of federal poverty guidelines (included on page 5), I am under 55 years of age, and I fit one of the following categories:

- I am currently employed
- I am actively seeking employment
- I am going to school

~ If you are currently on Disability/Social Security and are under the age of 55, you may apply for clinic services. However, please note that first priority is given to people who are in the workforce or attempting to join the workforce ~

Child /Teenager Applications: **If you are applying for someone under the age of 18 please call before applying. There may be other services available for your child. Our number is 594-6996.**

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- The Knox County Health Clinic Dental Program provides exams, cleanings, sealants, simple fillings, and extractions for children and adults, whose family earnings are at or below 200% of federal poverty guidelines (included on page 5).

- Priority is given to those who need dental care for pain and infection control and to children who have been unable to receive dental care.

- The charge for dental services is either $10.00 or $20.00 per visit based on your total gross household income.

- **Proof of income must be provided with the completed application**, such as copies of pay stubs, SSI statements, or tax returns. Fees must be paid prior to scheduling an appointment.

- **You must cancel your appointment at least 24 hours in advance or you will still be charged. Patients who fail to cancel with proper notice are no longer eligible for services.**

- We now have a program to provide acrylic partials and dentures to those who qualify. Patients are responsible for payment of 50% of the denture laboratory fees. You will need to pay approximately $100 per arch. This fee must be paid in advance.

- Volunteer dentists and hygienists staff the dental offices. Your first visit will be with a hygienist who will take X-rays and clean and examine your teeth. Also, you are entitled to a cleaning once a year. After the initial visit, if you need fillings, you will be put on a waiting list to see one of the Clinic's volunteer dentists.

- You can expect a wait of several months to over a year to receive care from a volunteer dentist. The program is not done on a first come first serve basis, but is based on priority. We regret the wait, but with so many needing services, this is the best that we can do. If you need extractions, we will refer you to the local oral surgeons.

- Please call the Knox County Health Clinic Dental Program at 594-6996 for more information.

****My initials here show that I have read, understand and agree to all written above: _____**

Knox County Health Clinic Dental Program
Adult Patient Information

Patient Name:____ Date:____________________
Address:____
Phone (home):_________________(work):__________________(cell):____________________
Birth Date:________________ Email Address:____
Emergency contact name and phone
number:____
Do you have any dental insurance? Yes No MaineCare? Yes No MaineCare #:___________

Health Information

Have you ever had any of the following? Please check those that apply:

__AIDS
__Allergies____________
__Artificial Joints
__Asthma
__Blood Disease
__Cancer
__Diabetes
__Dizziness
__Epilepsy
__Excessive Bleeding
__Fainting
__Glaucoma
__Growths
__Hay Fever
__Head Injuries
__Heart Attack
__Heart Disease

__Anemia
__Arthritis
__Heart Murmur/Mitral Valve Prolapse
__Hepatitis
__High Blood Pressure
__Jaundice
__Kidney Disease
__Liver Disease
__Mental Disorders
__Metal Allergy
__Nervous Disorders
__Pacemaker
__Pregnancy
Due Date:_____
__Radiation Treatment
__Respiratory Problems

__Rheumatic Fever
__Rheumatism
__Sinus Problems
__Stomach Problems
__Stroke
__Transfusions
__Tuberculosis
__Tumors
__Ulcers
__Venereal Disease
__Codeine Allergy
__Penicillin Allergy
__Other:
____

Do you smoke? Yes No
If yes, how much? ____

Medications

Medication	Dosage	When Taken

Have you ever had any complications following dental treatment? Yes No
If yes, please explain:____
____
Have you been admitted to a hospital or needed emergency care during the past two years?
Yes No If yes, please explain:____
____
Are you now under the care of a physician? Yes No
If yes, please explain:____
____
Name of Physician:_____________________________ Phone:_____________________________
Do you have any health problems that need further clarification? Yes No
If yes, please explain:____
____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ _________________________
Signature of Patient Date

Consent for services: I consent to be treated by the Knox County Health Clinic Dental Program. I understand that as a patient of the program, I need to give at least 24 hours advance notice if I need to cancel my appointment. If I fail to do so, I understand that I will lose my appointment fee and will be ineligible for services from the program in the future. I also understand that the clinic can only provide basic dental care such as exams, cleanings, simple fillings, extractions, and if I qualify for them, dentures. Crowns, bridges, root canals and extensive periodontal work will not be provided.

____ _________________________
Signature of Patient Date

Dental Information
Date of last visit:____________ Former dentist(s):_____________________________________
Reason you no longer see dentist:____
Reason for last visit:______________________ Reason for this visit:____________________
How often do you brush?___________________ How often do you floss?_________________
Please check any problems that you've had: __bad breath __bleeding gums __pain
__loose teeth __broken fillings __periodontal treatment __sores in mouth __decaying teeth
__grinding teeth __clenching teeth __oral cancer __mouth pain __jaw pain
__other:____
Are you afraid of dentists or dental care? Yes No If so, explain why:____________________
____
Have you ever had any serious problems associated with dental treatment? Yes No If so, please explain:____

Referral Information
Person or agency referring:____________________________ OR self-referred? Yes No
How did you learn about the program:____
Are you currently employed? Yes No Is so, where?_________________________________
Are you currently seeking employment? Yes No
Are you involved in employment or self-improvement program? Yes No If yes, which program? __CED __ASPIRE __Adult Ed __Other:____________________________________
How does your dental condition affect your ability to work or seek work?_____________
____
How would your life improve if able to receive dental care?______________________________
____
Is transportation to the dental office needed? Yes No
Is child care needed during the dental appointment? Yes No
What else should the Clinic staff and/or dentist be aware of?_____________________________
____

Income Information
# of people in the household:_____
Amount of gross (please circle) monthly/yearly income:______________
Proof of income is required (most current tax return is best source). Source of proof of income:____

The fee for patients from households with incomes of 100% of poverty guidelines is $10.00.
The fee for patients from household with incomes of 101% up to 200% of poverty guidelines is $20.00.

Fee	% of Federal Poverty Guidelines	Monthly Income per # Living in Household					
		1	2	3	4	5	6
$10	100%	$903	$1,214	$1,526	$1,838	$2,149	$2,461
$20	200%	$1,805	$2,428	$3,052	$3,675	$4,298	$4,922

****Please send the appropriate fee with the application.***
Fee collected: ____$10 ____$20

Fee has been collected:____
Signature of Clinic staff or referring agent Date

____
Signature of patient Date

Fee and application form has been received from referral agency:_____
Date:________________

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Patient of Record Clarification Statement

I understand a dentist has agreed to provide the immediate services for which I have been (my child has been) scheduled through Knox County Health Clinic Dental Program; however, I realize I am not a patient of record for this dentist, but rather of the Knox County Health Clinic Dental Program. I understand if I need future services to be provided through the Knox County Health Clinic Dental Program, I may be scheduled with another dentist. If I have any questions or concerns about my dental care, I will contact the Knox County Health Clinic Dental Program, and not the participating dentist.

Patient Signature:____ Date:__________