KNOX CLINIC
Your Mid Coast Health Net

Mailing Address: 22 White Street Rockland, ME 04841
Physical Address: 1019 Commercial Street, Rockport ME
Phone: 207-593-1699 www.KnoxClinic.org

Adult Dental Program Application

You must be able to check each box below to qualify for services:

You live in Knox County, Waldoboro, or Lincolnville? ☐
Your family's earnings at or below 200% of federal poverty guidelines (*see next page*) ☐
You do NOT have private dental insurance (excluding MaineCare) ☐
You are between the ages of 18 and 55, or if you are over 55, you are working at least 20 hours a week ☐

Please fill out a child application for those under 18 years old.
If you do not qualify for services through our dental program, please call us at 207-593-1699 for other resources.
If you are eligible for Medicare there are options for dental coverage for you at no cost. Please call Spectrum Generations at 207-701-5089 for more information.

Adult Patient Information

Today's Date: _____

Patient Name:_____ Birth Date: _____

Street Address:_____ Town:_____ Zip Code: _____

Home Phone:_____ Cell Phone:_____

Alternate contact name and phone number:_____

email: _____

Dental & Medical Health Information

Name of Physician: _____ Physician Phone #: _____

Have you had a joint replacement surgery in the past 2 years? Yes ☐ No ☐

If Yes, are you required to take an antibiotic (PREMED) prior to dental treatment? Yes ☐ No ☐

Estimated date of last dental visit:_____ Former dentist(s):_____

What are your primary concerns regarding your dental health? Please explain: _____

_____

_____

Please bring a list of your medications with you to your first appointment.

Income Information **-** Proof of income is required (recent tax return is best, or 1-month of recent pay stubs)

Amount of gross monthly income (before deductions): $_____

# of people in your household (those you are financially responsible for, not roommates): _____

Our appointment fees:

- $20 Hygiene (cleaning) appointments for those up to 100% federal poverty guidelines (fpg) (see next page)
- $40 Hygiene appointments for 101 to 200% fpg
- $10 Exam by dentist, all patients up to 200% fpg
- $40 Restoration appointment (fillings, extractions etc.), all patients up to 200% fpg
- $100 per arch for acrylic partials/dentures, as available.
- We are applying to be able to bill MaineCare, after which there will be no Clinic fees for covered services.

The chart below will tell you what fee to provide with the application. This fee will cover your first visit.

Visit Fee	Federal Poverty Guidelines	Monthly Income per # Living in Household					
		1	2	3	4	5	6
$20	100%	$1,073	$1,452	$1,830	$2,208	$2,587	$2,965
$40	200%	$2,147	$2,903	$3,660	$4,417	$5,173	$5,930

Knox Clinic Dental Program Guidelines, Expectations, & Consent – Please Read Carefully and Sign Below

- Priority is given to those who need dental care for pain and infection control. There is often a wait for services.
- The fee charged per visit is based on your gross household income. The fees must be paid before your visit to receive service. To make a credit card payment please call 207-593-1699.
- We provide exams, cleanings, sealants, fillings, partials, some dentures or partials, simple extractions, and most x-rays. Crowns, bridges, root canals, oral appliances, and extensive periodontal work will not be provided.
- **Proof of income must be provided with the completed application**, such as copies of 1 month's worth of pay stubs, SSI statements, or most recent tax return.
- **You must cancel your appointment at least 24 hours in advance. If you do not cancel your appointment with 24 hours advance notice you will be dismissed from the dental program and lose your appointment copay.** *There are a lot of people in need of dental care, so we must enforce this. Please keep your appointments!*
- If I have any health/dental changes, I will inform the dental staff at the next appointment.
- I am responsible for my own dental care. It is my responsibility to contact the office to schedule my appointments. I understand I must re-qualify for services every year to continue in the dental program.
- To the best of my knowledge, all of the above answers and information provided are true and correct.

_____ _____

Signature of Patient Date

****In order to schedule an appointment, please mail completed application *with proof of income & applicable fee* to the MAILING address at the top of this application****

Please call our office at 207-593-1699 with any questions, thank you

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CLINIC USE ONLY

Fee collected: ____$20 ____$40 _____ Signature of Clinic Staff / Date

Revised January 2022