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.

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.

Do you have active Mainecare? Yes ☐ Mainecare Id # _____ No ☐

Income Information **-** Proof of income is required if you **do not** have Mainecare(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 if you do not have Mainecare:

- $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

The chart below will tell you what <u>fee to provide with the application IF you do not have Mainecare</u>. 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%	$1,225	$1,704	$2,152	$2,600	$3,049	$3,497
$40	200%	$2,510	$3,407	$4,304	$5,200	$6,097	$6,994

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

- 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.
- **<u>Proof of income must be provided with the completed application if you do not have Mainecare</u>**, such as copies of 1 months' worth of pay stubs, Social Security statements or most recent tax return.
- **You must cancel your appointment at least 24 hours in advance. <u>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.</u>** *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

<u>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**</u>**

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

Revised April 2024