

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.

Knox County Health Clinic Dental Program
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594-6996

- 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: _____**

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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594-6996**

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: _____