KNOX CLINIC
Your Mid Coast Health Net

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CHILD DENTAL PROGRAM APPLICATION

Please complete this application and return it *with proof of income and appropriate fee* to:

Knox County Health Clinic, 22 White St. Rockland, ME 04841

Do you qualify for Dental Clinic services?

Yes if: you live in Knox County, Waldoboro or Lincolnville, your family's earnings are at or below 200% of federal poverty guidelines (included on next page) and you are 16 years of age or under. Older patients please use the adult dental program application.

Child Patient Information

Date: _____

Patient Name:_____ Birth Date: _____

Parent/Guardian Name: _____ Birth Date: _____

Street Address:_____ Town:_____ Zip Code: _____

Phone (home):_____ (work):_____ (cell):_____

Emergency contact name and phone number:_____

Health Information

Do you have any Allergies? Yes No
If yes, to what? _____

Please discuss any serious medical problems that your child has had: _____
_____
_____

Medications

Medication	Dosage	When Taken

Child's Physician: _____ Phone #: _____
Please describe your child's current physical health: ___ Good ___ Fair ___ Poor
Please explain:_____

Dental Information

Date of last visit:_____ Former dentist(s):_____

How often does child brush?_____ How often does child floss?_____

Is the child's water fluoridated? Yes No Is the child taking fluoridated supplements? Yes No

Please check any problems that child has had: __pain __loose teeth __ fillings __sores in mouth

___ decaying teeth ___ grinding teeth ___ oral cancer ___ mouth or jaw pain __ other: _____

Does/did your child have any of the following habits?

___ lip sucking/biting ___ nail biting ___ nursing bottle habits ___ thumb/finger sucking

Is your child afraid of dentists or dental care? Yes No If so, explain why:_____

_____

Has your child ever had any serious problems associated with dental treatment? Yes No

If so, please explain:_____

Income Information

Does your child have any dental insurance? Yes No MaineCare? Yes No MaineCare #:_____

Is there proof that child is participating in MaineCare or Cub Care? Yes No If yes, there is a 5$ fee.

If not, please fill out the following:

# of people in the household (not roommates) :_____ Amount of gross monthly income:_____

Proof of income is required (most current tax return is best source).

The chart below will tell you what fee to provide with the application, this will cover your child's first visit.

Fee	Federal Poverty Guidelines	Monthly Income per # Living in Household					
		1	2	3	4	5	6
$10	100%	$981	$1,328	$1,674	$2,021	$2,368	$2,714
$20	200%	$1,962	$2,655	$3,348	$4,042	$4,735	$5,428

The fee for children with MaineCare is $5.00.
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.

Please send the appropriate fee with the application.

Dental Program Guidelines and Expectations – Parent/Guardian -Please Read Carefully and Sign Below

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

- 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 previously. There is often a wait for services.

- The charge for dental services is either $5.00, $10.00, or $20.00 per visit based on your total gross household income. This must be paid prior to or at your visit to receive service.

- **Parent/Guardian proof of income must be provided with the completed application**, such as copies of pay stubs, SSI statements, or tax returns.

- **You must cancel your appointment at least 24 hours in advance or you will still be charged. If you do not cancel your appointment with proper notice you will be removed from the dental program and will not be able to receive dental program services. There are a lot of people in need of dental care, so we have a one strike and you're out policy!**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child ever has any health changes, I will inform the dental staff at the next appointment without fail.

Consent for services: I consent for my child to be treated by the Knox County Health Clinic Dental Program. I understand that

- I must give at least 24 hours advance notice if I need to cancel my child's appointment.
- **If I do not cancel my child's appointment in advance, I will lose the appointment fee, my child will be ineligible for future dental services and they will be removed from the program.**
- The dental program can only provide basic dental care such as exams, cleanings, simple fillings, extractions, dentures. Crowns, bridges, root canals and extensive periodontal work will not be provided.

_____ _____

Signature of Parent/Guardian Date

CLINIC USE ONLY

Fee collected: ____$5 ____$10 ____$20

Fee has been collected:_____ _____

Signature of Clinic staff Date