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)*

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:____

Dental & Medical Health Information
Name of Physician:____________________________ Physician Phone #: ________________________
Have you had a join 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☐
List medications you are taking, or bring a list with you to your first appointment:
____
Date of last dental visit:____________ Former dentist(s):____________________________________

How often do you brush?__________________ How often do you floss?________________

What is your primary concerns regarding your dental health? Please explain: ________________________

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Income Information
Amount of gross (before deductions) monthly income: $___________

# of people in the household (those YOU are financially responsible for):_____

Proof of income is required (most current tax return is best source or 1-month of recent pay stubs).
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.

If your household income is over 200% of the poverty guidelines you do not qualify for services through the dental program.

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

Fee	Federal Poverty Guidelines	Monthly Income per # Living in Household					
		1	2	3	4	5	6
$10	100%	$1,041	$1,409	$1,778	$2,146	$2,514	$2,883
$20	200%	$2,082	$2,818	$3,555	$4,292	$5,028	$5,765

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 fees (co-pays) for dental services rendered by our hygienist are either $10, or $20. Visits to the dentist are either $20 or $40. The fee charged per visit is based on your gross household income. The fees must be paid before your visit to receive service. At this time we cannot accept card payments.
- We have a program to provide some types of acrylic partials and dentures to those who qualify. Patients pay **$100** per arch.
- The Knox Clinic Dental Program provides 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 or you will still be charged. 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 have a one strike and you're out policy!**
- 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, therefore, it is my responsibility to contact the office to schedule any appointments. If I am not seen for a period of three (3) years, I will be considered inactive and will be required to re-apply and qualify for services.
- 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****

****CLINIC USE ONLY****

Fee collected: ____$10 ____$20

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Signature of Clinic Staff/Date

Revised February 2019