

## 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 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

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: \_\_\_\_\_

\_\_\_\_\_

**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, please call us for other resources.

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%	\$1,073	\$1,452	\$1,830	\$2,208	\$2,587	\$2,965
\$20	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 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. To make a credit card payment please call 593-1699.
- 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. 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

\_\_\_\_\_  
Signature of Clinic Staff/Date