DENTIST DELIVERING SMILES, VISION, AND HEARING AID PROGRAMS

What should I bring?

1. Entire households previous month's income (30 days' worth)
2. Federal Tax Return for previous year
3. Proof of Howard County Residency (Utility bill in your name)
4. Current Photo ID
5. Birth Certificate

Suggested items to bring:

1. Medical history
2. Medication list

Dentist Delivering Smiles Criteria:

200% Federal Poverty Level

No insurance of any kind

$25.00 Co-Pay

Vision Program:

200% Federal Poverty Level

No vision insurance

$30.00 Co-Pay if <100%

$40.00 Co-Pay if <130%

$50.00 Co-Pay if >131%

Hearing Aids Program:

200% Federal Poverty Level

No insurance that would cover hearing devices

$50.00 Co-Pay if <100%

$75.00 Co-Pay if <130%

$100.00 Co-Pay if >131%

HOWARD COUNTY DENTISTS DELIVERYING SMILES, VISION, AND HEARING AIDS APPLICATION

Medicare: Yes No Medicaid: Yes No Health Insurance: Yes No
Dental Insurance: Yes No Vision Insurance: Yes No

This application is for (Circle One) Dental Vision Hearing Aids

Name: _____ Date of Application: _____

Street Address: _____ City: _____

State: _____ Zip: _____ County: _____ Township: _____

Telephone: _____ Age _____

Birth Date: _____

Social Security Number: _____/____/_____

Emergency Contact: _____ Relationship: _____

Telephone: _____

Members of Household:

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicant's Place of Employment: _____

Sources of income for household:

_____ $_____

_____ $_____

_____ $_____

_____ $_____

_____ (Total For Month)

Additional Assistance:

TANF: _____ HUD: _____ Trustee: _____

Food Stamps: _____ EAP: _____ Other: _____

Howard County Dentists Delivering Smiles

PatientName: _____

Do you have a Medical Doctor: Yes No

Physicians name and phone number: _____

Date of lastvisit: _____

Your current physical health is EXCELLENT GOOD FAIR POOR

Please Explain: _____

_____

Do you have or have you ever experience any of the following?

Please circle all that apply

Allergies	Artificial Bones/Joints	Artificial Valves	Arthritis
AIDS/HIV	Blood Transfusion	Cancer	Chemotherapy/Radiation
Congenital Heart Defects	Diabetes	Difficulty Breathing	Emphysema/Asthma
Drug/Alcohol Concerns	Angina/Chest Pains	Epilepsy/Seizures	Fainting Spells
Fever Blisters/Herpes	Heart Attack	Heart Murmur	Heart Surgery/Pacemaker
Hemophilia/Anemia	Abnormal Bleeding	Hepatitis/Liver Problems	High/Low Blood Pressure
Kidney/Bladder Problems	Latex Allergy	Cosmetic Surgery	Mitral Valve Prolapse
Psychiatric Care	Emotional Problems	Rheumatic Fever	Severe/Frequent Headache
Sinus Problems	Stroke	Thyroid Disease	Sexually Trans. Disease
Ulcers/Colitis	Other: _____		

Are you taking any prescriptions or over the counter medications (Please list each one)

_____

_____

_____

_____

Have you had problems with bleeding? YES NO

Have you had any adverse experience to Local Anesthesia? (Used for numbing) YES NO

Have you been advised to take Antibiotic Medication before any dental procedures YES NO

For Women: Are you pregnant YES NO Week: _____

Are you nursing? YES NO Taking Birth Control Pills? YES NO

Major Monthly Expenses:

Rent:	$_____	Child Care:	_____
Utilities:	$_____	Garnishment:	_____
Food:	$_____	Medical/RX:	_____
Child Support:	$_____	Other:	_____
Transportation:	$_____	Other:	_____

Additional information (if needed):

_____

_____

_____

Do you require wheelchair access? Yes No

Do you use a cane or a walker? Yes No

Name of last dentist seen: _____ Telephone: _____

Date of last visit: _____

Ho will you get to your dental appointment? _____

DENTAL QUESTIONS

Chief Complaint _____

In pain? ○ Yes ○ No ○ On & Off ○ Constant ○ Sharp ○ Dull ○ Throbbing

Sensitive to: ○ Hot ○ Cold ○ Sweets ○ Pressure ○ Chewing

Location: ○ Right side ○ Left side ○ Upper ○ Lower ○ Front ○ Back

Is there any swelling: ○ Yes ○ No What is swollen? ○ Gum ○ Face ○ Neck

Is a tooth Loose? ○ Yes ○ No Do they have a fever? ○ Yes ○ No

Any other information?

Application reviewed by: _____ (name)

_____ (agency)

_____ (date)

money collected:

○ Yes

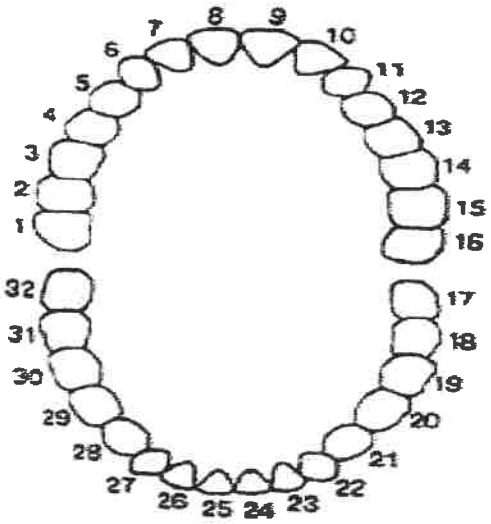
○ No

Upper Right:

1. 3rd Molar (wisdom tooth)
2. 2nd Molar (12-year molar)
3. 1st Molar (6-year molar)
4. 2nd Bicuspid (2nd premolar)
5. 1st Bicuspid (1st premolar)
6. Cuspid (canine/eye tooth)
7. Lateral incisor
8. Central incisor

Lower Right:

25. Central incisor
26. Lateral incisor
27. Cuspid (canine/eye tooth)
28. 1st Bicuspid (1st premolar)
29. 2nd Bicuspid (2nd premolar)
30. 1st Molar (6-year molar)
31. 2nd Molar (12-year molar)
32. 3rd Molar (wisdom tooth)



Upper Left:

9. Central incisor
10. Lateral incisor
11. Cuspid (canine/eye tooth)
12. 1st Bicuspid (1st premolar)
13. 2nd Bicuspid (2nd premolar)
14. 1st Molar (6-year molar)
15. 2nd Molar (12-year molar)
16. 3rd Molar (wisdom tooth)

Lower Left:

17. 3rd Molar (wisdom tooth)
18. 2nd Molar (12-year molar)
19. 1st Molar (6-year molar)
20. 2nd Bicuspid (2nd premolar)
21. 1st Bicuspid (1st premolar)
22. Cuspid (canine/eye tooth)
23. Lateral incisor
24. Central incisor

Please Circle the Tooth/Teeth that are causing you pain and write a brief explanation of the symptoms including pain level.

In the box below please list the available times for appointments and good times to get ahold of you. Also any other notes that may affect your availability.

Monday

Tuesday

Wednesday

Thursday

DENTISTS DELIVERY SMILES, VISION, AND HEARING AIDS
PATIENT RESPONSIBILITY AGREEMENT

1. I agree to provide medical, dental, and financial information and documents upon request.
2. I give my permission to the intake coordinator to obtain information relative to my eligibility from appropriate physicians, dentists, individuals, and agencies.
3. I give my consent to the intake coordinator to release pertinent information to doctors/dentists to whom I am being referred.
4. I understand that I am not assured an examination nor that I will be accepted following an examination.
5. I understand that any doctor/dentist to whom I may be referred is not under any obligation to maintain me as a patient.
6. I understand that doctor/dental diagnosis and treatment of my medical problems is solely up to the doctors/dentists to whom I am being referred. I also understand that refusing to follow the physicians care plan may result in my dismissal from the program.
7. I agree to notify the dentist at least **twenty-four hours** in advance if I cannot keep an appointment. Failure to do so will disqualify me from the program.
8. I understand that I must conduct myself in an appropriate manner in the doctor's office. Failure to do so will disqualify me from the program.
9. I hereby release Dentists Delivering Smiles, Vision, Hearing Aids and any of its employees, associates or volunteers from any responsibility for changes in my health or well-being as a result of the care given.

_____

Patient Name Date

Or

( ) Minor, under 18 years

( ) Physical/Mental Condition

_____

Spouse, Parent, Legal Guardian or Representative Date

_____ _____

Relationship Witness Date