CHILDREN'S DENTAL CLINIC OF JACKSON COUNTY, OREGON

FAMILY REPORT

Please rememember to read both sides of this information and include *all* information requested before sending it to the clinic.
Please remember that you do not send the application to your child's school, but to the address on this family report.
INCOMPLETE APPLICATIONS WILL DELAY TREATMENT!

Parents / Guardians

		Circle One			Lives in Household	
Father's Name _____	Married	Divorced	Single		Yes	No
Mother's Name _____	Married	Divorced	Single		Yes	No
Guardian's Name _____	Married	Divorced	Single		Yes	No
Guardian's Name _____	Married	Divorced	Single		Yes	No

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Dependent's Name	**Date of Birth**	**Sex**	**School**
1. _____	_____	M F	_____
2. _____	_____	M F	_____
3. _____	_____	M F	_____
4. _____	_____	M F	_____
5. _____	_____	M F	_____

Household Income: List all wage earners living in the household

Name	Monthly Wage/Salary		Relationship to Children
1. _____	_____	Steady Y N Seasonal Y N	_____
Employer _____	_____	Occupation _____	
2. _____	_____	Steady Y N Seasonal Y N	_____
Employer _____	_____	Occupation _____	
3. _____	_____	Steady Y N Seasonal Y N	_____
Employer _____	_____	Occupation _____	

Other Sources of Household Income

	Monthly Amount		Monthly Amount
Unemployment Payments	$ _____	Alimony Received	$ _____
Social Security	$ _____	Interest/Investment Income	$ _____
Disability income	$ _____	Rental Income	$ _____
Welfare/Public Assistance	$ _____	Self Employment Income	$ _____
Food Stamps	$ _____	Retirement Income	$ _____
Child Support Received	$ _____	Other _____	$ _____

Insurance

Are the children covered by a dental insurance polcy? Y____ N____ _____

Are the children covered by the Oregon Health Plan? Y____ N____ If yes, which dental plan? _____

Do you have medical insurance? Y____ N____ _____

Dental History

Do your children see a regular family dentist?_____ When were they last seen? _____ / _____ /_____

Have any of your children been treated at the Children's Dental Clinic? _____

Name _____ Date last treated _____ / _____ /_____

Name _____ Date last treated _____ / _____ /_____

Name _____ Date last treated _____ / _____ /_____

Name _____ Date last treated _____ / _____ /_____

Current Problems

Do your children have dental pain?_____ Explain _____

Do your children have large visible cavities? _____

Verification

Parents signature _____ Date _____ / _____ /_____ Witness _____

CHILDREN'S DENTAL CLINIC

Of Jackson County

229 Stewart Avenue, Medford, OR 97501
(541) 789-4249 Fax (541) 789-5284

Dear Parent or Guardian,

Do you have school-age children who have dental needs that are beyond your financial capabilities?

The Children's Dental Clinic of Jackson County is a cooperative effort of the Southern Oregon Dental Society, Southern Oregon Dental Hygienists, and Rogue Valley Medical Center. Its purpose is **TO PROVIDE DENTAL CARE TO UNINSURED CHILDREN OF LOW INCOME FAMILIES.**

The program, funded by the Walker Fund of Oregon Community Foundation, Medford Kiwanis, City of Medford, City of Ashland and United Way, is open to children whose parents meet the financial requirements of the clinic. **CHILDREN HAVING DENTAL INSURANCE OR OREGON HEALTH PLAN ARE NOT ELIGIBLE FOR THE PROGRAM.**

To inquire about your child's eligibility, please complete the family report form on the reverse side of this letter. **MAIL IT, ALONG WITH PROOF OF INCOME; SUCH AS, YEAR-TO-DATE PAY STUBS, OR W-2 WITHOLDINGS TO:**

Children's Dental Clinic
229 Stewart Ave.
Medford, OR 97501

To process your application quickly, please read both sides of the application and include *all* information requested before sending it to the clinic. And please remember that you do not send the application to your child's school, but to the address on this family report.

You'll be contacted regarding your eligibility.

Sincerely,

Larry Ware
President, Board of Directors
Children's Dental Clinic