APLICACION PARA SERVICIO DE SALUD DENTAL

Nombre del Estudiante _____ Fecha _____
Apellido Nombre

Direccion _____ Portland, OR. Zip _____

Telefono _____ Fecha de Nacimiento _____

Escuela _____ Distrito _____ Grado _____

INFORMATION LABORAL

Nombre del Padre _____ Empleado por _____
Apellido Nombre

Profesion _____ Direccion _____

Seguro social# _____ Telefonoo del Trabajo _____

Nombre de la Madre _____ Empleada por _____
Apellido Nombre

Profesion _____ Direccion _____

Seguro Social# _____ Telefono del Trabajo _____

En caso de emergencia, llamar _____ **Telefono** _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _____ Phone _____

Insured's Employer _____ Name of Insured _____

SSN# of Insured _____ Insured's Birthdate _____

Please fill out secondary if applicable.

Secondary Insurance Co. _____ Phone _____

Insured's Employer _____ Name of Insured _____

SSN# of Insured _____ Insured's Birthdate _____

Por fabor marque cual de las siguientes aplican:

Tarjeta de Medical ☐ ; **Desayuno/Almuerzo Gratis** ☐ ; **Seguro Dental** ☐

Toda esta informacion es valida y cierta hasta donde yo se.

Firma del padre de Familia _____ **Fecha** _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS APPLICATION.

The Friends of Creston Children's Dental Clinic (FCCDC)
At Creston School
4701 SE Bush St..
Portland, OR 97206
503-916-5808

EMERGENCY AND PREVENTIVE / RESTORATIVE PROGRAM GUIDELINES

Assistance League Portland Children's Dental Center provides free emergency dental care to Portland Public School area school children of low income families.

Eligible children may apply for regular dental care and check-ups which are available under a preventive / restorative dental care program. Preventive treatments precede restorative care and includes a yearly examination, prophylaxis and x-ray, home care instruction, and fluoride and sealant applications.

Prior to treatment of any kind, parental consent and signature is required, granting the dentist permission to proceed with such treatment as deemed appropriate by the dentist.

PATIENT / PARENT RESPONSIBILITIES

Cooperation is required of both parent and patient to insure continued qualification for the program. It is expected that patient will be quiet and cooperative in the dental chair. The patient must learn good oral hygiene habits. Parents must keep the patient's medical history and other information current.

Cancellation of appointments must be made 24 hours in advance. If the patient arrives more than 10 minutes late, the appointment is subject to cancellation. Late or broken appointments without a reasonable excuse, or failure to fulfill any other responsibilities mentioned above, may jeopardize future patient qualification for dental services. A patient will not be rescheduled for more appointments if two appointments have been missed without proper notification to The Friends of Creston Children's Dental Clinic.

I have read and understand the above guidelines. I hereby give permission for my child to receive free dental care and request that the dentist proceed with such treatment as deemed appropriate by the dentist.

Patient Name _____

Parent or Guardian Signature_____ Date _____