Form #_____

MARIN COUNTY DENTAL CARE FOUNDATION
DENTAL REFERRAL FORM

NAME_____SCHOOL_____GRADE_____

BIRTHDATE_____MALE ( ) FEMALE ( ) AGE_____

ADDRESS_____PHONE_____

PARENT/GUARDIAN_____

EMPLOYER: FATHER:_____Gross Monthly Income $_____

EMPLOYER: MOTHER:_____ Gross Monthly Income $_____

Work Phone #_____/_____ Total number in family _____
Father Mother

Is child covered by: Dental Insurance Yes ( ) No ( )
Medi-Cal Yes ( ) No ( )
Other financial assistance Yes ( ) No ( )

Do you have a family dentist? If yes, give name of dentist_____

If family dentist is unavailable, would you accept a dentist assigned by the Dental Care Foundation?
Yes ( ) No ( )

General statement as to present family need (unusual circumstances, responsibilities)

_____

_____

_____

I/We have read the general information statement provided and request aid from the Marin County Dental Care Foundation. I/We agree to cooperate with Marin County Dental Care Foundation by keeping all dental appointments and making any co-payments as agreed. We also give permission for the Dental Care Foundation to contact our/my employer for verification of income/employment.

_____
Parent/Guardian Date

(For foundation and/or referral source only)

Name_____Phone_____
Nurse ( ) Dentist ( ) Physician ( )

Amount of aid requested $_____ Co-payment $_____Percentage _____

Disposition: Granted ( ) Refused ( ) Reason _____

Commenced_____Completed_____Total Value_____Total Amount_____