Sex: M / F Ethnicity: Hispanic / Non-Hispanic Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: (Please Circle one) White African/American Asian Native American

Birth Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s license #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Veteran Y / N

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

(Street) (Apt. #)

County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ Work: (\_\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* \_\_\_\_\_\_\_\_\_

Cell Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle one:** Employed Unemployed Retired Disabled

**How did you hear about ACORN?** Family/Friend Media School Church Outreach Doctor/Dentist Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| EMERGENCY CONTACT: |  | PHONE: |  |
| PHYSICIANS NAME: |  | PHONE: |  |
| PHARMACY: |  | PHONE: |  |

**SLIDING FEE SCALE APPLICATION**

The following information is based on **all** household members

|  |  |  |  |
| --- | --- | --- | --- |
| TOTAL # of ADULTS |  | TOTAL # of CHILDREN |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SOURCE | SELF | SPOUSE | OTHER | TOTAL |
| Net Wages, Salaries, Tips, Prior Year Tax Return |  |  |  |  |
| Income from Business, self-employment and dependents |  |  |  |  |
| Unemployment, Workers Comp, Social Security, Public Assistance, Veteran’s Payments, Survivor benefits, Pension or Retirement Compensation |  |  |  |  |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside household and/or miscellaneous sources |  |  |  |  |

Note: Copies of prior year tax returns, three most recent pay stubs or other information verifying income is required before discount is approved. I certify that the family size and income information shown above is correct.

(Circle **Y** or **N** to indicate if you have ever had any of the following):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Acid Reflux/GERD | **Y** | **N** | Herpes | **Y** | **N** |
| AIDS / HIV | **Y** | **N** | High Blood Pressure | **Y** | **N** |
| Alcohol Dependency | **Y** | **N** | Jaundice | **Y** | **N** |
| Anemia | **Y** | **N** | Kidney Disease | **Y** | **N** |
| Arthritis, Rheumatism | **Y** | **N** | Liver Disease | **Y** | **N** |
| Artificial Heart Valves | **Y** | **N** | Mental Disorders/Psychiatric Care | **Y** | **N** |
| Artificial Joint | **Y** | **N** | Mouth Sores | **Y** | **N** |
| Asthma | **Y** | **N** | Nervous Disorders | **Y** | **N** |
| Bleeding Abnormally / Excessive | **Y** | **N** | Pacemaker | **Y** | **N** |
| Bleeding gums | **Y** | **N** | Past Surgeries **type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Y** | **N** |
| Blood Disease | **Y** | **N** | Radiation | **Y** | **N** |
| Cancer | **Y** | **N** | Respiratory Disease | **Y** | **N** |
| ***when & type:*** | | | Rheumatic Fever | **Y** | **N** |
| Chemical/Drug | **Y** | **N** | Seasonal Allergies | **Y** | **N** |
| Chemotherapy | **Y** | **N** | Shortness of Breath | **Y** | **N** |
| Clenching, Grinding, Jaw Popping | **Y** | **N** | Sinus Trouble | **Y** | **N** |
| COPD/Emphysema | **Y** | **N** | Sleep Apnea | **Y** | **N** |
| Diabetes | **Y** | **N** | Stroke **Year: \_\_\_\_\_\_\_\_\_\_\_** | **Y** | **N** |
| Dry Mouth | **Y** | **N** | Swollen feet and ankles | **Y** | **N** |
| Epilepsy | **Y** | **N** | Teeth Sensitivity | **Y** | **N** |
| Fainting/Dizziness | **Y** | **N** | Thyroid Problems | **Y** | **N** |
| Head/Neck/Back Injury | **Y** | **N** | Tobacco Use/Smoker | **Y** | **N** |
| which: | | | Tuberculosis | **Y** | **N** |
| Heart Attack  **Year:\_\_\_\_\_\_\_\_\_\_** | **Y** | **N** | Tumor **when & type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Y** | **N** |
| Heart Disease | **Y** | **N** | Ulcer | **Y** | **N** |
| Heart Murmur | **Y** | **N** | Venereal Disease | **Y** | **N** |
| Hepatitis, ***type***: | **Y** | **N** | Other: | **Y** | **N** |

Have you ever been told to take medication before a dental procedure? **Y** / **N** Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was your last dental visit?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any medication allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List all medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you taking or have you ever taken medication for bone density?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WOMEN:**

Are you pregnant? Y/ N Due Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Are you nursing? Y / N

Are you taking birth control? Y/N

I certify that the above medical information is correct.