

APPLICATION FOR DENTAL SERVICES
Lincoln-Lancaster County Health Department
Dental Division
3131 O Street, Lincoln, NE 68510



Lincoln-Lancaster County
Health Department

Parent/Guardian Name _____ **Relationship to Patient** _____ **Social Security Number of Parent/Guardian** _____

Address (Number, Street) _____ **City/State** _____ **Zip Code** _____ **County** _____

Home Phone _____ **Cell Phone** _____ **Email Address** _____

How would you like to be contacted for reminder calls? Phone Text Email

List All Household Members with Income	Current Employer/Phone	Hourly Wage	# of Hours worked per week	Gross Monthly Income	How often do you get paid: (Hourly, Weekly, Bi-Weekly, Monthly, or Annually)
1.					
2.					
3.					
4.					

Do you or anyone within your household receive any of the following?

1. Unemployment	\$ _____
2. Social Security	\$ _____
3. Disability Benefits	\$ _____
4. Child Support/Alimony	\$ _____
5. Retirement Benefits	\$ _____
6. Supplemental Income from any other source (family, sponsorship, etc.)	\$ _____
7. Household Income/Resources not previously identified	\$ _____

Are you a U.S. citizen? Yes No
 If not, what is your residency status? _____
 Are you a current resident of Lincoln or Lancaster County? Yes No
 How long? _____

What is your primary language? _____
 Country of Origin _____

Do you need an interpreter for dental services? Yes No
 Interpreter's Name: _____

Is the parent/or applicant applying for dental services a college or graduate student? Yes No
 Name of School _____

Is your spouse a college or graduate student? Yes No
 Name of School _____

Is the parent/or applicant on a visiting or student visa?

Yes

No

HEALTH OR DENTAL COVERAGE		Insurance Company	Family members covered by the programs
Do you or anyone within your household receive Medicaid, Kids Connection, or Aid to Dependent Children?	___ Yes ___ No		
Are you or your family covered by Health Insurance?	___ Yes ___ No		
Are you or your family covered by Dental Insurance?	___ Yes ___ No		

LIST ALL MEMBERS IN HOUSEHOLD

Name	Relationship	Date of Birth	Age	Race (Use list below)	Hispanic/Latina Ethnicity	Medicaid Number
1.					___ Yes ___ No	
2.					___ Yes ___ No	
3.					___ Yes ___ No	
4.					___ Yes ___ No	
5.					___ Yes ___ No	
6.					___ Yes ___ No	
7.					___ Yes ___ No	
8.					___ Yes ___ No	
9.					___ Yes ___ No	
10.					___ Yes ___ No	

Race: White Black/African American Asian
 American Indian/Native American Hawaiian/Pacific Islander Other

Immediate Health Concerns or Problems

Other Comments

I declare that the above information is complete and accurate. I understand that any information falsely reported can result in a re-evaluation of eligibility for services and possible dismissal from the dental clinic.

Print Name

Signature

Date

<p>For Office Use Only: Total Yearly Gross Income Reported for Household \$ _____ Client Fee Step _____ Staff Comments _____ _____</p>
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