City of Hamilton
Public Health Services,
Dental Program

DENTAL CLINIC APPLICATION

Mail, drop off or fax to:

110 King Street West 3rd floor
Hamilton, ON L8P 4S6
Phone: (905) 546-2424 x3789
Fax: (905) 546-2649

Applicant:

Last Name □ Mr. □ Mrs. □ Ms. □ Miss.	**First Name**	Birthdate (dd/mm/yy)
Address	City	Postal Code
Home Phone #:	Work Phone#:	Cell Phone#:
Employed: □ Yes □ No Current Employer:		
Are you self-employed? □ Yes □ No	Are you enrolled full-time in a college or university? □ Yes □ No	

Spouse / Partner:

Last Name □ Mr. □ Mrs. □ Ms. □ Miss.	**First Name**	Birthdate (dd/mm/yy)
Address	City	Postal Code
Home Phone #:	Work Phone#:	Cell Phone#:
Employed: □ Yes □ No Current Employer:		
Are you self-employed? □ Yes □ No	Are you enrolled full-time in a college or university? □ Yes □ No	

Please list children and other family members living in the same household

Name	Age	Birthdate (dd/mm/yy)	Enrolled in HSO? Yes or No	School / University / College Name	Employed? Yes or No

(**Please Turn Page Over)**

Have any family members been treated in our Dental Clinic before? □ Yes □ No If yes, when?_____

Are any family members receiving Orthodontic (braces) treatment □ Yes □ No

Have you applied to The Special Supports Program? □ Yes □ No

Do you have dental insurance? □ Yes □ No

How long living in Ontario? Applicant: _____ Spouse: _____ Children: _____

If less than one year, indicate your status:
□ Landed Immigrant □ Refugee □ Sponsored □ Student Visa □ Work Visa

If self-employed what is your annual gross income? _____

Do you or any family member(s) receive social assistance? □ Yes □ No If yes, please check box below:
□ Ontario Works (OW, Welfare) □ Interim Federal Health □ Ontario Disability Support Program (ODSP)
□ Ontario Basic Income Program
Who receives monthly payment? Name _____Case ID# _____

Please list any other forms of financial support you receive (i.e. food, housing):

_____

Note: Copies of most recent tax return(s) or Notice of Assessment(s) must be provided for all adults, any employed children and other family members listed on this application. If self-employed, please provide most recent tax return(s) and Statement of Business Activity.

The information voluntarily included on this form is collected under the *Personal Health Information Protection Act*. The City of Hamilton's Public Health Services may use this information to plan or deliver public health programs and services, arrange payment for treatment and care, conduct continuous quality improvement activities, teach employees and students and comply with legal and regulatory requirements. Questions about the collection, use and disclosure of personal health information should be directed to the Public Health Services Privacy Officer at (905) 546-2424 ext. 2946 or phsprivacy@hamilton.ca

I declare the information on this application is true and complete to the best of my knowledge. I understand that giving false or incomplete information or not advising of changes in my situation may result in suspension or termination of my family's treatment. I will abide by the City of Hamilton's policy on zero tolerance of harassment and violence.

Signature: _____ Date: _____

_____
For Office Use Only, Comments:

Approved _____Denied _____Date _____

_____
James Fung, Dental Clinic Supervisor