AURORA CHILDREN'S DENTAL SERVICE
APPLICATION

PLEASE FILL OUT FORM AND RETURN TO THE SCHOOL NURSE

Child's Name:_____Age:_____
School:_____Grade:_____
Home Address:_____
Home Telephone:_____

Father's Name:_____Mother's Name:_____
Place of Work:_____Place of Work:_____
Work Phone:_____Work Phone:_____

Financial – Annual Take Home Pay
Father: $_____
Mother: $_____
Other: $_____

1. Do you have dental insurance for your family? Yes_____ No_____
2. Are you receiving assistance from the Department of Public Aid? Yes_____No_____
3. Do you have a general dentist? Yes_____No_____
   If yes, Dentist's Name: _____

I request the help of Aurora Children's Dental Service in securing the needed dental care for my child. I will promise to have an adult with my child at all dental visits. I will call the office of the dentist 24 hours in advance if the appointment cannot be kept. I understand my child will be dropped from the program if there are unnecessary cancellations or broken appointments.

Signature of Parent or Guardian: _____

If this application is accepted you will be notified by the school nurse.

FOR SCHOOL NURSE USE ONLY

Date_____

_____ was recommended for urgent care during a recent dental screening.
STUDENT'S NAME

_____
Nurse or Health Tech Signature
Please forward to Aurora Children's Dental Service