WODA
West Orange Dental Alliance

Qualification Application for Emergent Dental Care

Patient Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State Zip code

Driver's License #: _____ Sex: M F

Date of birth: _____/_____/ _____ Years residing in West Orange County _____

Primary phone: _____ Alternate Contact Phone: _____

Name of Contact: _____ Relationship to applicant: _____

Email Address: _____ Do you reside at the address listed? N Y

How did you hear about us? _____

Area & Reason for Dental Need

Please circle the area of your emergent dental issue below:

Upper Lower Right side Left side Front/Anterior Other: _____

_____

_____

_____

Prescription given by hospital/doctor office if applicable: _____
Last Physical Exam: _____
Last Dental Exam: _____

Financial Information

Employed Unemployed Child/Student Homeless Veteran Disabled

Employer (if applicable): _____ Full Time or Part-time

Do you have dental insurance: N Y Do you have or medical insurance: N Y
Medical Insurance Company Name: _____

Dental Insurance Company Name: _____

Marital Status: Married Divorced Single Widowed Dependent

How many people live in your household? _____

Please list the occupants currently living in your household below and Gross Income which does NOT include any type of assistance: (If dependent and no income please list DEPENDENT).

Self _____ Gross Income _____
Spouse/Partner _____ Gross Income _____
Child & Age _____ Gross Income _____
Child & Age _____ Gross Income _____
Child & Age _____ Gross Income _____
Child & Age _____ Gross Income _____
Additional _____ Gross Income _____
Additional _____ Gross Income _____

Are you currently receiving any charitable assistance? N Y

If Yes, please list the type of assistance and the monthly monetary amount below:

_____

_____

_____

Please list any other sources of income SSI, child support, alimony, disability, food stamps, free school lunch, childcare, dental, etc. and the monthly monetary amount below:

_____

_____

_____

Documentation Needed

Please see the below documents required to approve eligibility and list what you can submit upon screening;

Proof of Residency: _____

One document that shows your name with the address you reside at; Examples: Valid license or ID, Current mail with postmark, Any type of bill, current residential lease,

Proof of Household Income: _____

Paycheck stubs of each household member for the last 14 days. Other income IE: Unemployment, Disability, Medicare/Medicaid, Social Security, Food Stamps.

Patient Acknowledgement

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my personal and financial situation. I understand that the information I have given is subject to verification by the West Orange Dental Alliance and does not automatically enroll/approve my application into the program.

_____ _____ _____
Signature of patient/parent or guardian Printed name patient/parent or guardian Date