Pediatric Dental Fund of The Hamptons, Inc.
P.O. Box 2675, East Hampton, NY 11937 / 631.329.6828

PARENT/GUARDIAN AGREEMENT FOR CHILD'S PARTICIPATION IN THE PEDIATRIC DENTAL FUND PROGRAM

Medicaid Patient Plan/Carrier: _____ Medicaid Number: _____
Child Health Plus #_____
Other Insurance Name: _____ Policy Number:_____

Attach copy (front & back) of Medicaid/Child Health Plus or Insurance Card

Please Note: Non-Medicaid Patients; $35. per visit fee will be charged per patient

Qualify for Free Lunch → Total Monthly Income $_____ Attach Pay Stub

# of Adults in Household _____ # of Children (under age 21) in household _____

I, _____ am the parent/legal guardian of _____.
Parent/Legal Guardian (Print) **Child/Participant (Print)**

Child's Age: _____ Birthdate: _____ Child's Sex: Male Female
Child's Race: White African American Hispanic Asian American Native American

Mailing Address: (Fill in mailing address)

PLEASE READ CAREFULLY!

I agree to see that transportation is provided for him/her to the dentist's office. I understand that if I must cancel an appointment, **24 hour notice is required.** I understand that failure to keep an appointment without prior cancellation will result in my child's dismissal from the program. .

I agree to inform the dental office that my child is a **PDF** (Pediatric Dental Fund) Patient each time I call to schedule an appointment.

Below is a list of dentist or dental clinics that have provided prior treatment to my child.

Name of Dentist	**Address/Telephone**	**Dates of Treatment**

If requested, I agree to sign authorizations to release previous dental records to the dentist to which the Pediatric Dental Fund of the Hamptons, Inc. shall refer my child.

I authorize my child's school to provide a statement of qualifications for free or reduced lunch in order to participate in this program. I hereby authorize the dentist to release any information acquired in the course of my treatment necessary to process the payment of my dental bills to the Pediatric Dental Fund of the Hamptons.

_____
(Signature of Parent or Guardian) (Date)

Day:_____ Evening: _____
_____
(Telephone Number) (Emergency Contact Number)