

Income	For YOU	For SPOUSE	For Children	For Other	
Gross wages, salaries, and tips					\$
Social Security & Pensions					\$
Annuity & veteran benefits					\$
Child support & alimony					\$
Self employment & other					\$
Total					\$

Zero Income

PLEASE FILL OUT ONLY IF YOU HAVE NO SOURCE OF INCOME

Name of last employer: _____ Date of last employment: _____

Please explain how your basic needs have been met:

Food: _____

Utilities: _____

Shelter: _____

Clothing: _____

I, _____, certify that I have had no source of income since _____.

All Applicants: PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW.

- I agree to be responsible for my Child's Dental bills.
- I also agree to notify A to Z Children's Dental Clinic if we become eligible for any other form of coverage.
- I understand that if I provide false or incomplete information, I may no longer qualify for a fee discount.
- I certify that the above information on this application is correct and all sources of income required have been reported. I further understand that I will need to update my application every six months even if no changes occur.

Signature: _____ Date: _____

Office Use Only

Patient Name	Discount	Date of Service	Approved by
---------------------	-----------------	------------------------	--------------------