



City of Hamilton Public Health Services Dental Clinic Application

City of Hamilton
Healthy & Safe Communities
Public Health, Dental Services
110 King St., West, 3rd Floor
Hamilton, ON L8P 4S6
P: 905.546.2424 ext. 3789
Fax: 905.546.2649

Note: If you are a sponsored immigrant or in Canada on a work or student visa you do not qualify for dental clinic services

1. Do you have dental insurance? Yes No **If yes**, you must seek dental care at a private dental office.

2. Do you or anyone in your household receive any of the social service benefits listed below?
 - Ontario Works (OW)
 - Ontario Disability Support Program (ODSP)
 - Interim Federal Health (IFH)
 - Non-Insured Health Benefits (NIHB) for First Nations and InuitYes No **If yes**, who is the recipient? _____

3. Do you receive any other form of support? (i.e. Child Tax Benefit). Yes No

4. Have any of your family members been treated in our Dental Clinic before?
 Yes No **If yes**, when? _____

Applicant:

Last Name	First Name	Birthdate (dd/mm/yy)
Address	City	Postal Code
Home Phone #:	Work Phone#:	Cell Phone#:
Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No Current Employer:		
Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you enrolled full-time in a college or university? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Spouse / Partner:

Last Name	First Name	Birthdate (dd/mm/yy)
Address	City	Postal Code
Home Phone #:	Work Phone#:	Cell Phone#:
Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No Current Employer:		
Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you enrolled full-time in a college or university? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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List children and other family members living in the same household

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

Note: You must include copies of the most recent Notice of Assessment(s) from the Canada Revenue Agency for all adults, any employed children and other family members listed on this application.

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 agree to abide by the City of Hamilton's policy on zero tolerance of harassment and violence.

Signature: _____ Date: _____

Mail, drop off or fax your completed application package to:

City of Hamilton Dental Services
110 King St., West, 3rd Floor, Hamilton, ON L8P 4S6
Fax: 905.546.2649

For Office Use Only, Comments:

Approved Denied Date: _____

(Please Print)
Dental Clinic Supervisor