DENTISTS ORGANIZED FOR VETERANS
Angela F. Bayat DDS

To meet all your dental healthcare needs, please fill out this form completely and accurately.

GENERAL APPLICATION FORM

Applicant Name ___________________________________ SS#/SIN_________________________________

Veteran File# _________________ Date__________Affiliation_______________________________________

Welcome to the DOV Project. The free dental services provided are **not** intended for all military veterans especially if they are in a financial position to pay for dental care. Rather, if you are a veteran who does not have the financial means through yourself or your family to afford on going dental treatment, you may be eligible for DOV services. In addition, if you have qualified for DOV services but at some point in the future your circumstances change and your financial position allows you to pay for dental services, you may no longer qualify to be a DOV patient.

If you do not qualify, you may be seen at our office Mt. Diablo Family Dentists which serves the general population. They provide exceptional care and as a veteran, you will receive dental services at significantly discounted rates and you may use your insurance. Please fill out the following application and we will quickly begin the process of evaluating whether you are eligible for DOV services.

To qualify, the following general criteria must be met although other factors will be taken into consideration:

- You must be a veteran of the armed services.
- You must have been discharged honorably, however there are exceptions on a case by case basis.
- Your gross household income may not exceed $34,000.00 per year if you are single or $38,000.00 per year if you have a family.
- You do not have additional assets or financial resources such as a spouse, family, investments, property or insurance to pay for dental care.

In addition, you will be asked to supply copies of your discharge papers, military identification card and tax returns for the previous 2 years.

DOV requires that all veteran applicants submit the following paperwork. If all required documents are not submitted with this application, the application will not be processed. If there are extenuating circumstances, please contact the DOV office to discuss your case.

The following documents must be submitted for verification:

- Veteran complete valid DD214. If you do not have a copy, please contact the Veterans Service Office in Stockton, CA at 209-486-2916. They can retrieve a copy for you to provide to us.
- Copy of current Veteran ID card such as: VA ID card, Armed Forces card, Uniformed Services ID card.
- Copy of driver's license
- Copy of last two (2) years of tax returns. If you have not or do not file taxes, we will need to see alternative documents which illustrate your fiscal situation. If necessary we will run a credit check/background check to satisfy our criteria for fiscal need.
- Completed original of the DOV application
- Completed HIPPA agreement attached with this application allowing DOV access to needed medical information relating to the veteran's dental treatment.

PATIENT INFORMATION (CONFIDENTIAL)

Name____Birthdate_____________Gender _______________________

Home Phone_____________________ Cell Phone _____________________Email___________________________

Service Branch _____________ Last Entry Date ________ Last Discharge Date ________ Discharge Type ________

Address____City_____________________State___Zip/P.C.______

Check Appropriate Box: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Spouse Name________________________Employer_______________________Work Phone__________________

Whom may we thank for referring you?____

Person to contact in case of emergency____

DO YOU/SPOUSE HAVE ANY HEALTH/DENTAL INSURANCE? ☐ Yes ☐ No If yes, please fill out the following:

Name of Insured____Relationship to Patient_______________

Birthdate_______________________SS#/SIN______________________________Date employed______________

Name of Employer_____________________________Union or Local#_______________Work Phone_____________

Address of
Employer_________________________________City__________________State___________Zip/P.C.___________

Insurance Company______________________________Group #__________________Policy/ ID#_______________

Ins. Co.
Address_____________________________________City________________State________Zip/P.C._________

How much is your deductible?_______________How much have you used?________Max. Annual Benefit_________

FINANCIAL PROFILE

Current Employer____ How long employed____________

Address of
Employer_____________________________________City___________State__________Zip/P.C.__________

Name of
Spouse____SS#/SIN____________________________

Date Of Birth _____________________________Military Service Dates ___________ Branch ______________

Name of Employer_____________________________________ How long employed ______________________

Address of
Employer_____________________________________City___________State__________Zip/P.C.__________

Gross annual income from employment_______________Other/Benefit __________________________________

If you are married, gross annual income of your spouse ______________________ Other income ______________

Do you own a home or other property? ________ If so, what is the market value? __________________________

Other assets ____

I. PATIENT DENTAL HISTORY

Name of Previous Dentist and Location____________________________ Date of Last Exam____________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet/sour foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficulty with extractions in the past?	☐	☐
12. Have you ever had prolonged bleeding following extractions?	☐	☐
13. Have you ever had orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement ________________	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth or gums?	☐	☐
Do you like your smile?	☐	☐

II. PATIENT DENTAL HISTORY

Physician______________________________Office Phone_____________________Date of Last Exam___________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness with the last 5 years? If yes please explain________________ ________________________________	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _________________________________ _________________________________ _______	☐	☐
4. Have you ever taken Fen-Phen/ Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Women Only:		
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐
9. Are you allergic to or have you had any reactions to the following?		
• Local Anesthetics (e.g. Novocain)	☐	☐
• Penicillin or any other Antibiotics	☐	☐
• Sulfa Drugs	☐	☐
• Barbiturates	☐	☐
• Sedatives	☐	☐
• Iodine	☐	☐
• Aspirin	☐	☐
• Any Metals (e.g. Nickel, Mercury, etc.)	☐	☐
• Latex Rubber	☐	☐
• Other (please list) _____________________________________ _____________________________________		
10. Do you have a persistent cough or throat cleaning not associated with a known illness (lasting more than 3 weeks?)	☐	☐

Please describe any medical conditions which are related to your service in the military.

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11. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsion	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ______________		

DO you have or have you ever had: osteoporosis/osteopenia (ie. Taking bisphosphonates) - yes/no?

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The information I have provided will be used by DOV to determine my financial status and I give DOV permission to run a credit check or use industry standard means to verify any of the information I have supplied. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health and disqualify me from participating in the DOV Project and receiving free dental care.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payer's and/ or health practitioners.

X____ Date ____________________

Signature of patient

Doctor's Comments ____

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Signature______________________________________Date ____________________

PATIENT CODE OF CONDUCT AND UNDERSTANDING
Contract of Mutual Support and Respect

This contract between DOV and ______________________ made on this Date______________ states quite simply that both parties will treat each other and all of the resources involved in bringing such care to veterans, each other's time, the experience of serving this country and each other's person hood with the utmost respect, understanding and kindness. Accountability is crucial for this program to work.

1. Use of Narcotics
The American Dental Academy and the California Dental Academy have determined that for treatment of dental pain, pharmacy grade medications such as Tylenol 3 are the optimal choice for treatment. Therefore, all narcotics such as hydrocodone will not be prescribed by any of the doctors or used in our office unless there are extenuating circumstances. In such cases, your physician will be required to prescribe such medication.

2. Missed Appointments, Cancellations
Because of this critical need by veterans and high expense of dentistry, every appointment made and treatment time slot are concretely limited, as every single appointment represents a crucial resource for DOV. A 2-strike policy is enforced wherein if a veteran misses two appointments, whether through 48-hour cancellation or rescheduling, that veteran will be reassigned to the secondary priority pool for no less than 90 days, after which their case will be reviewed and they will be interviewed for return to the primary patient group and treatment.

If a veteran misses two appointments without contacting DOV or replying to contact from DOV, they will no longer be eligible for any DOV services for 1(one) year and must reapply after that time period for reconsideration.

3. Compliance with Prescribed Treatment and Maintenance of Excellent Dental Healthcare
The services and materials provided to veterans free of charge is possible because of the generosity of donors. A veteran who does comply with his or her prescribed course of treatment, fails to maintain proper oral health through detrimental behavior such as smoking, drug use, poor diet or simply neglects the proper oral hygiene will no longer qualify for free dental services from DOV. **In addition, you are required to come in for your regular cleanings at least twice (2) per year to maintain the work and treatment that has been provided to you. Failure to maintain your cleaning schedule can lead to revoking your eligibility for receiving treatment from the DOV Project.**

4. Open Communication with the DOV Clinical Team
Both parties will commit to open and full communication as needed in order to get the most out of the dental care program that DOV provides. It is the responsibility of the veteran to be open and prompt in communication with DOV staff. This is a minimum responsibility and applies to all phone calls, text and emails. The veteran must remain aware of his or her health status and communicate fully with DOV as needed in regard to events that could affect his or her dental condition.

Signed ____ Date __________________________________