GREAT NEWS!

Dear Parent/Legal Guardian:

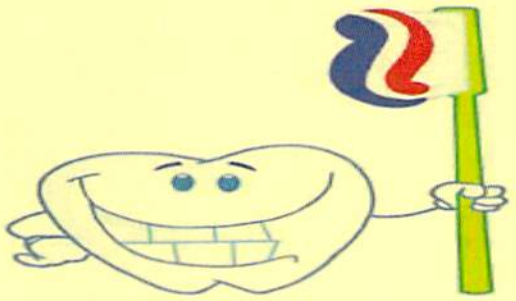
We are so excited to announce that the Pender County Health Department Mobile Dental Clinic along with dentist, Dr. Kathy Barnes, and her staff will be at your child's school soon!!

The Mobile Dental Clinic provides dental services to children during school and after school hours. If you would like your child to be seen, please fill out the attached form and return it to your child's teacher as soon as possible. Our dental services are also available for school staff, parents and all members of the community. If you have dental insurance, we can file it. We can also check to see if your student qualifies for Medicaid or our Sliding Fee Scale.

If you have any questions, please call 910-471-3250.

We look forward to meeting and treating your child!
Sincerely,

Pender County Health Department
Mobile Dental Clinic



****TEACHERS PLEASE PLACE COMPLETED FORMS IN THE NURSE BOX****

PENDER COUNTY HEALTH DEPARTMENT

MOBILE DENTAL CLINIC

803 S. Walker Street, Burgaw, NC 28425
(910) 471-3250

Dr. Kathy Barnes, DDS

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: ____

MAILING ADDRESS: _____
City State Zip Code

DATE OF BIRTH: _____ MALE_____ FEMALE_____ SOCIAL SECURITY#:

TEACHER: _____GRADE: _____ AFTER SCHOOL PROGRAM: YES_____ NO

PARENT/LEGAL GUARDIAN

LAST NAME: _____ FIRST NAME: _____ MI:

CELL PHONE #:_____ DAYTIME PHONE #:

EMAIL_____ EMERGENCY CONTACT/PHONE #:_____

PAYMENT INFORMATION

DOES YOUR CHILD HAVE MEDICAID OR HEALTH CHOICE? YES_____ NO_____

IF YES, PLEASE PROVIDE MEDICAID OR HEALTH CHOICE CARD #:_____

INSURANCE:

DOES YOUR CHILD HAVE DENTAL INSURANCE? YES_____ NO_____

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

POLICY HOLDER'S NAME: _____ SSN#:_____ DATE OF BIRTH_____

INSURANCE CO. NAME & ADDRESS: _____ SUBSCRIBER #:_____

GROUP PLAN #:_____ INSURANCE PHONE #:_____

EMPLOYER: _____

IF POSSIBLE, PLEASE SEND A COPY OF YOUR INSURANCE CARD, FRONT AND BACK. THANK YOU

PRIVATE PAY:

IF YOU DO NOT HAVE INSURANCE AND WANT TO APPLY FOR A DISCOUNT PLEASE PROVIDE THE FOLLOWING INFORMATION:

TOTAL NUMBER OF FAMILY MEMBERS LIVING IN THE HOME: ADULTS: ____ CHILDREN: ____

TOTAL MONTHLY HOUSEHOLD INCOME $_____ EMPLOYER: _____

DO YOU RECEIVE UNEMPLOYMENT? YES_____ NO_____ AMOUNT: $_____

DO YOU RECEIVE DISABILITY? YES_____ NO_____ AMOUNT: $_____

DO YOU HAVE ANY OTHER FORM OF INCOME? YES_____ NO _____ AMOUNT: $_____

If Yes Please Explain: _____

*PLEASE NOTE: PROOF OF INCOME MAY BE REQUESTED. THANK YOU

PATIENT DENTAL AND MEDICAL HISTORY

DENTAL HISTORY

HAS YOUR CHILD EVER BEEN TO THE DENTIST BEFORE? YES_____ NO_____

IF YES, WHEN AND WHERE WAS HIS/HER LAST DENTAL VISIT: _____

WERE X-RAYS TAKEN AT THAT VISIT? YES_____ NO_____

HAS YOUR CHILD EVER HAD A BAD OR SCARY EXPERIENCE AT THE DENTIST? YES_____ NO_

HOW OFTEN DOES YOUR CHILD BRUSH HIS/HER TEETH: _____

DOES ANYONE HELP YOUR CHILD BRUSH HIS/ HER TEETH? YES_____ NO_____

DOES YOUR CHILD FLOSS HIS/HER TEETH? YES_____ NO_____

HISTORY OF (Check all that apply)

___BLEEDING GUMS ___THUMB SUCKING ___BOTTLE HABITS ___CAVITIES

___BAD BREATH ___PAIN IN TEETH ___SNORING ___GRINDING TEETH

___ COLD SORES/CANKER SORES

IS YOUR CHILD IN PAIN NOW WITH HIS/HER TEETH? YES_____ NO_____
EXPLAIN: _____

DO YOU HAVE ANY CONCERNS WITH YOUR CHILD'S TEETH? YES_____ NO_____
EXPLAIN: _____

YOUR CHILD'S MEDICAL HISTORY (Check all that apply)

___ADD/ADHD ___ AIDS/HIV ___ ANEMIA ___ CANCER

___AUTISM ___BEHAVIORAL PROBLEMS ___DOWN SYNDROME ___SPECIAL NEEDS

___ CELIAC (Gluten Allergy) ___DEVELOPMENTAL ___HEMOPHILIA ___DIABETES

___EPILEPSY/SEIZURES ___HEPATITIS ___KIDNEY DISEASE ___ ASTHMA

___HEARING PROBLEMS ___ RHEUMATIC FEVER ___PSYCHIATRIC CARE ___TRANSPLANT

___EYE PROBLEMS ___GLASSES/CONTACTS ___HIGH BLOOD PRESSURE ___TB

___HEART CONDITIONS (Please list) _____

PLEASE LIST THE FOLLOWING:

HAS YOUR CHILD EVER EXPERIENCED AN ALLERGIC REACTION TO ANYTHING? YES_____ NO_____
EXPLAIN: _____

DOES YOUR CHILD TAKE ANY MEDICATIONS: IF SO, PLEASE LIST: _____

SURGERIES/HOSPITAL STAYS: _____

OTHER HEALTH CONDITIONS NOT LISTED: _____

PERMISSION

Each child receives a comprehensive examination ($83), radiographs ($44), a cleaning ($72), fluoride ($50) and preventive sealants ($55/tooth) if needed on their initial visit. You are responsible for these fees unless you provide Medicaid or Dental Insurance information necessary in order to file a claim. If you do not have any coverage you may provide proof of income to see if you qualify for a discount on the above fees. I give permission for my child _____ to receive these services provided by Dr. Kathy Barnes without my presence.

After dental treatment is completed on my child, I agree that Dr. Kathy Barnes may file claims for dental care with the insurance company or other payer information that I have provided.

Signature of Parent/Legal Guardian: Date: