

**MACOMB COUNTY HEALTH DEPARTMENT
DENTAL CLINIC
27690 VAN DYKE AVE
STE B
WARREN, MI 48093
(586) 465-9152**

APPLICATION FOR DENTAL CARE

NAME _____ DATE OF BIRTH _____

SPOUSE'S NAME _____ DATE OF BIRTH _____

ADDRESS _____
STREET CITY STATE ZIP

PHONE _____
HOME CELL BUSINESS

CHILDREN'S NAME (LIVING IN HOUSEHOLD UNDER THE AGE OF 21) DATE OF BIRTH

CURRENT PLACE OF EMPLOYMENT _____

GROSS PAY _____
PER WEEK OR PER MONTH OR PER YEAR

SPOUSE'S CURRENT PLACE OF EMPLOYMENT _____

GROSS PAY _____
PER WEEK OR PER MONTH OR PER YEAR

DO YOU RECEIVE ANY OTHER INCOME SUCH AS SOCIAL SECURITY, PENSION FUNDS, OR STATE
DISABILITY? _____ **PLEASE ATTACH A COPY OF THAT INCOME STATEMENT.**
YES NO

OTHER PERTINENT INFORMATION THAT WOULD BE OF ASSISTANCE IN DETERMINING
ELIGIBILITY FOR DENTAL CARE:

***PLEASE ATTACH COPIES OF CURRENT PAY CHECK STUBS SHOWING DEDUCTIONS AND
YEAR TO DATE EARNINGS. IF YOU HAVE NO INCOME, PLEASE ATTACH A LETTER FROM
SOMEONE WHO WILL ASSUME FINANCIAL RESPONSIBILITY FOR YOUR SERVICES.**

DATE _____ SIGNATURE _____

***APPLICATIONS AND PROOF OF INCOME MUST BE SUBMITTED YEARLY. ***