Bethesda
HEALTH CLINIC

APPLICATION FOR DENTAL SERVICES ONLY
Screening available Monday – Thursday 10:00 AM – 1:30 PM

Name _____Date of Birth_____ Social Security Number_____

Total Family Income _____ Week/Month/Year Number of people in household _____

Do you have dental insurance? Y / N

Phone # _____

Address _____
City ST Zip Code

Please bring the following items for your admissions interview:

- A current picture ID
- Applicable proof of income (For example: current income tax return, social security awards letter, etc)

_____
Signature

Waiver of Liability for Treatment

By signing below, you acknowledge: 1. That Bethesda's volunteer healthcare providers (such as physicians, physician assistants, registered nurses, LVN, pharmacist, podiatrist, dentists, dental hygienists or any such persons who are retired or otherwise defined or included under Texas Law or Federal Law) are providing health care that is not administered for or in expectation of compensation 2. That there are limitations on you or your family's ability to recover damages from the volunteer or the Bethesda Health Clinic in exchange for your receiving health care or dental services.

It is intended that this WAIVER be as broad and expansive as allowed by the law.

_____ _____ _____
Printed Name Signature Date

_____ _____ _____
Admissions Printed Name Admissions Signature Date