For internal use
Enrollment Confirmed
Date: By:
Appointing
Date: By:

Lifelong Dental Program Enrollment Form

General Information ☐ **Check here if you have applied to or been previously enrolled in LDP**			
Legal Name (Last, First, Middle) (printed):		Date of Birth:	
Residential Address:	Mailing Address (if different):	Okay to Send Mail? ☐ Yes ☐ No	
Phone Number: Okay to Leave Voicemail? ☐ Yes ☐ No	How will you be getting to your appointments? ☐ Public Transportation ☐ Car ☐ Other: _____ ☐ I don't know		
Case Manager Name/Agency:	Case Manager Phone #:	Preferred Language: Language spoken at home: Do you need an interpreter? ☐Yes ☐ No	
Oral Health Assessment			
Current Dentist/Dental Clinic Name:		Current Medical Provider/Clinic Name:	
When was your last dental appointment (please provide approximate date or year)? Do you have dentures? ☐Yes ☐ No		Last Primary Care Visit (Date): Most Recent Viral Load Count: _____ Date: _____ Most Recent CD4 Count: _____ Date: _____	
Do you have dental insurance? ☐Yes ☐ No ☐ Unknown If yes, dental insurance name: _____ Dental Insurance ID#: _____		Do you have medical insurance? ☐Yes ☐ No ☐ Unknown If yes, medical insurance name: _____ Do you have Medicaid: ☐Yes ☐ No Do you have Medicare: ☐Yes ☐ No	
What dental concerns or issues are you having currently?			

Consent for Services and Release of Information

I authorize the Lifelong Dental Program (LDP) and its staff to enroll me into the program and to exchange information (written, verbal and/or fax/email) for the purpose of ongoing care coordination of my oral health needs. I understand that LDP staff may disclose personal health information (PHI) regarding the following: eligibility, billing, oral health needs, and medical and dental information used to make treatment or payment decisions and for appeals. I understand that this information may be shared with dental clinics, medical providers, case management agencies, and with Lifelong auditors and agents, but will otherwise be kept confidential.

I attest that I have received Lifelong's client rights and responsibilities, confidentiality policy and grievance information. I understand that I must renew my Ryan White eligibility every six months to remain active in the program. I further understand that I will be responsible for any fees related to missed appointments as per individual clinic policies. By signing below, I confirm that the information I have provided is accurate to the best of my knowledge. *This consent will expire upon termination of services, unless I revoke this consent in writing.*

Applicant Signature:	Date:

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