Dental Health Program

175 Sunset Ave
PO Box 2191
Toms River, NJ 08754
(732) 341-9700 Ext. 7624
Fax- (732) 831-6480
www.ochd.org

APPLICATION FOR DENTAL TREATMENT

Special Instructions for Contacting Person:
Home: ___________________________________
Cell: ___________________________________
Work: ___________________________________
Other: ___________________________________

Date: ______________________

Name of Child: __________________________________Age: ________ DOB: _____________________

Name of Parent/Guardian: ____

Home Address: ____

School District: __________________________ School: ___________________Grade: _____________

Is this child enrolled in New Jersey Family Care? Yes ___________ No ________________________

Medicaid? Yes ___________ No ____________ Dental Plan? Yes ________ No _______________

I certify that the above information is correct to the best of my knowledge and belief.

Signature of Parent or Person Responsible: ____

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OCHD Staff Title

OCHD Comments: ____

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