At Smile Doctors, we believe in the power of a smile to change lives!

We created the Smiles From the Heart Program to make orthodontic treatment accessible to more families. We love to see our patients change as their teeth change!

Please understand that we receive many applications for this program. Recipients are chosen based on a variety of factors. Smiles From the Heart applications are reviewed quarterly and applicants are notified directly.

APPLICATION CHECKLIST

___ Application: Completed as directed in black/blue ink (if you're applying on behalf of someone, please write "N/A" in the sections that you may not have information on at this time).

___ Applicant Essay: Please provide a handwritten essay describing how orthodontic treatment will change your life or the life of someone you know.

___ Two Photos: Close-up images of applicant while smiling.

QUALIFICATIONS

- Must reside within a reasonable distance from one of our clinic locations.
- Must have healthy dental hygiene practices and of had a dental check-up and cleaning within the past six months.
- Must have a need for orthodontic treatment.
- Must follow and abide by treatment plan set forth by the orthodontist.

SMILE DOCTORS SMILES FROM THE HEART PROGRAM PATIENT GUIDELINES

1. Smile Doctors “Smiles From The Heart” Program provides orthodontic treatment only. Extractions, dental cleanings, oral surgery, periodontal therapy, and any other treatment that may be necessary before, during, or after orthodontic treatment are the financial responsibility of the patient, their parents, or their legal guardian.

2. If the patient has cavities or periodontal disease (gum disease), these conditions must be remediated before orthodontic treatment begins. If cavities or periodontal disease occur during treatment, then braces may need to be removed and treatment stopped.

3. Patients must have a general dentist to verify that all necessary dental treatment has been completed before orthodontic treatment begins. In addition, the patient must maintain regular dental appointments and cleanings during orthodontic treatment.

4. During treatment, cavities can form around the braces if you have poor oral hygiene. If you do not maintain proper oral hygiene or if cavities form which are not remediated, the treating orthodontist has the option to remove the braces and end the orthodontic treatment. You will then be dismissed from the Smiles From The Heart Program.

5. If the patient is accepted into the Smiles From The Heart Program, orthodontic treatment will be provided by the assigned orthodontist only. If the patient moves away from the treating orthodontist, the Smiles From The Heart Coordinator will attempt to find another treating orthodontist; however, Smiles From The Heart cannot guarantee that this will be possible. If the patient moves before the orthodontic treatment finishes and Smiles From The Heart is unable to find a new orthodontist, the patient must advise their treating orthodontist and make any arrangements necessary to complete treatment. This includes finding a new orthodontist, which will become the patient’s financial responsibility, or having the current orthodontist remove the braces.

6. Regular orthodontic appointments are necessary to make sure the teeth move as expected and no unwanted movement occurs. It is the patient’s responsibility to make sure that all the scheduled appointments are kept. Failure to maintain regularly scheduled appointments on a continued basis is grounds for the treating orthodontist to remove the braces and end the orthodontic treatment.

7. Patients must completely follow the treatment plan recommended by the treating orthodontist, which will be explained to the patient before orthodontic treatment begins. Failing to follow the treatment plan gives the treating orthodontist the option to refuse treatment, to remove the braces, and to end the orthodontic treatment.

SMILE DOCTORS SMILES FROM THE HEART PROGRAM PATIENT GUIDELINES

8. During orthodontic treatment, a trusting relationship between providers and patients is vital to the success of the outcome of the case. Patients must maintain excellent hygiene by brushing and flossing and wearing appliances and rubber bands as instructed. Failure to comply with the treatment plan or maintain proper behavior so that the treatment can be delivered can result in refusal to continue orthodontic treatment or removing the braces and ending treatment.

9. Broken appliances or loose brackets and bands can cause damage to the teeth and the rest of the mouth. All patients must take special care not to eat hard or sticky foods or pull on the braces. If there is frequent damage to the appliances, the treating orthodontist has the option of removing the braces or charging you to repair the damage, which is not covered by the Smiles From The Heart Program.

10. One retainer, which is necessary to keep the teeth from shifting, will be provided as part of orthodontic treatment at no charge. If the retainer is damaged or lost, a fee will be assessed to fabricate a replacement.

11. Patients of the Smiles From The Heart program are expected to become advocates of the practice and may be asked to assist in promotional events and media events.

12. If a Smiles From The Heart patient is awarded treatment for Phase 1 treatment, an additional Smiles From The Heart application and process will need to be completed for Phase 2. A second Smiles From The Heart award isn't guaranteed should Phase 2 treatment be necessary.

I have read the following rules and I will ensure that the conditions above are met should I be selected to be a patient in the program.

Signature of applicant: _____

Date: _____

Signature of parent/ legal guardian (if applicable): _____

Date: _____

SMILE DOCTORS SMILES FROM THE HEART PROGRAM APPLICATION

Applicant's name: _____ Age _____

Male _____ Female _____

Parent or guardian's name (if applicable): _____
Phone: _____
Address: _____
City, state, zip: _____ Country _____

Does the applicant have dental insurance? ____Yes ____No

Number of people in applicant's household: _____

Annual household income: _____

Dental Needs

Do you have a dentist? _____ If yes, name of dentist: _____
Phone#: _____
Date of last dental visit: _____
Has a dentist recommended braces for you? _____

How did you hear about the Smiles From The Heart program? Contact person (relative, friend, etc.):

Name: _____Phone: _____

Relationship to Applicant: _____

Additional Information

Use this space to elaborate on any information not sufficiently explained in other areas.

_____
_____
_____
_____
_____

SMILE DOCTORS SMILES FROM THE HEART PROGRAM APPLICATION

Please read the following statements. If you understand and agree to the conditions, please sign and date the form at the bottom.

• I understand that I will need to provide personal information that includes but is not limited to medical, dental, and financial condition.
• I give my consent for the referral coordinator to obtain information from my child's physician, dentist, contact people I listed, and/or government or private agencies to determine their eligibility for the Smiles From The Heart program.
• I understand information provided by me or others as noted above may be given only to the volunteers involved in my child's treatment and will be held confidential.
• I give permission for the referral coordinator to share information about my child with one or more volunteer orthodontists in the Smiles From The Heart program.
• I realize that the application to the Smiles From The Heart program does not assure my child will be referred for an examination or that they will be accepted as a patient following an examination.
• I understand that Smile Doctors, who coordinates the Smiles From the Heart Program, will determine if my child is eligible for the program.
• I understand that Smile Doctors-affiliated orthodontists have volunteered to treat my child's existing condition only and are not obligated to provide donated care in the future.
• I understand the importance of keeping all scheduled appointments. Failure to do so, without at least 24-hour notice to the orthodontist, could disqualify me from obtaining further treatment through the program.
• To the best of my knowledge, the information provided on this form is a full and accurate disclosure of my current physical, medical, and financial status.

Signature of applicant or guardian: _____ **Date:** _____

Signature of person referring (if applicable): _____ **Date:** _____

PHOTOGRAPHY AND INFORMATION CONSENT FORM

I hereby give my permission to Smile Doctors to release my orthodontic records to a referred specialist or any subsequent treatment dentist or orthodontist. Smile Doctors may also utilize my records, photos, and videos for the purposes of professional consultations, research, education, lectures, and publications in professional journals, marketing efforts, social media sites or use on their website.

Print Name: _____

Signature: _____ **Date:** _____

If under 18, both parents must sign individually and as parent/guardian

Signature of parent or guardian: _____ **Date:** _____

Signature of parent or guardian: _____ **Date:** _____