



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 Parents/Guardians are notified directly.

Application Checklist

___ **Application:**

Completed as directed in Black/Blue ink

___ **Applicant Essay:**

Please provide handwritten essay describing how orthodontic treatment will change your life and how you will pay it forward.

___ **Report Card:**

Please provide your most recent Report Card.

___ **2 Photos:**

Close-up images of Applicant while smiling.

Qualifications

- Applicant must reside within a reasonable distance to our clinic locations.
- Applicant must be between the ages of 11 – 18.
- Have healthy dental hygiene practices and had a dental check-up within the past six months.
- Must have a need for orthodontic treatment.
- Must currently be enrolled in school.
- 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 for 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’s parents or legal guardians.
2. If your child has cavities or periodontal disease (gum disease), these conditions must be completely remedied before orthodontic treatment begins. If cavities or periodontal disease occurs during treatment, then braces will need to be removed and treatment stopped.
3. Your child must have a general dentist to verify that all necessary dental treatment has been completed before orthodontic treatment begins. In addition, your child must maintain regular dental appointments and cleanings during orthodontic treatment.
4. During the course of treatment, cavities can form around the braces if your child has poor oral hygiene. If your child does not maintain proper oral hygiene or if cavities form which are not remedied, the treating orthodontist has the option to remove the braces and end the orthodontic treatment. Your child will then be dismissed from the Smiles From The Heart Program.
5. If your child is accepted into the Smiles From The Heart Program, orthodontic treatment will be provided by the assigned orthodontist only. If you move away from the treating orthodontist, the Smiles From The Heart Coordinator will attempt to find your child another treating orthodontist; however, Smiles From The Heart cannot guarantee that this will be possible. If you move before the orthodontic treatment finishes and Smiles From The Heart is unable to find a new orthodontist, you must advise your treating orthodontist and make any arrangements necessary to complete treatment. This includes finding a new orthodontist, which will become your 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 your responsibility to make sure that all of 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. You and your child must completely follow the treatment plan recommended by your orthodontist, which will be explained to you before orthodontic treatment begins. If you fail to follow the treatment plan, the treating orthodontist has 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 the course of 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 by 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. Recipients 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 recipient 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.



Application for Smile Doctors Smiles From The Heart Program

Child's name: _____ Male ___ Female ___

Parent or guardian's name: _____ Phone: _____

Address: _____

City, state, zip: _____ County: _____

Child's date of birth: _____ Age: _____

Number of people in child's household: _____

| Name of each person | Age | Relationship to child |
|---------------------|-------|-----------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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

Name: _____ Phone: _____

Relationship to child: _____

Financial information

Household monthly income:

Parent or guardian #1 _____

Are you employed? ___ Yes ___ No

Place of employment: _____

Your monthly wages: \$ _____

Parent or guardian #2 _____

Are you employed? ___ Yes ___ No

Place of employment: _____

Your monthly wages: \$ _____

Are there any other sources of income for your household, such as Social Security, SSI, TANF, Unemployment, child support, etc.? If so, please indicate below:

Total monthly household income from all sources: \$ _____

Total value of child's & parent(s) savings: \$ _____

Total value of child's & parent(s) investments: \$ _____



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Parent or guardian must submit a copy of last year's federal tax return (1040, 1040a, or 1040ez) with this application.

Does the child receive medicaid benefits? Yes No Medicaid # _____
Does the child have dental insurance? Yes No

Dental Needs

Briefly describe the child's dental needs:

Does your child have a dentist? _____ If yes, name of dentist: _____
Phone#: _____ Date of last dental visit: _____
Has a dentist recommended braces for your child? _____
How will you ensure your child gets to dental appointments? _____

Please list other towns you can get to: _____

Smiles From The Heart approved professional to provide an assessment of your child (social worker, teacher, school counselor, clergy, etc.):

Name: _____ Phone: _____
Address: _____
City, state, zip: _____ County: _____
Institution: _____
Relationship to child: _____

Additional information

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



Parent or guardian must be willing to adhere to "Smiles From The Heart" Program rules; the patient must:

1. Have regular dental visits during the course of orthodontic treatment;
2. Maintain good oral hygiene;
3. Keep all regularly scheduled appointments
4. Take proper care of all orthodontic appliances;
5. Comply with all instructions given by orthodontist

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

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

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 in order 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, can and will disqualify my child 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 parent 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 video recordings 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 parent's must sign individually and as parent/guardian.

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

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

