Gift Of A Smile Application

Date of application:_____

APPLICANT INFORMATION

Name:_____Phone: (_____)_____(home)

Address:_____Phone: (_____)_____(cell)

City:_____State:_____Zip Code:_____County:_____

Email Address:_____

Date of birth:_____ Age:_____ Male: ☐ Female: ☐ Military Veteran: ☐

Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Contact Person Name (relative, friend, etc.): _____

Phone: (_____)_____Relationship to you:_____

Have you received services through a donated dental program before? ☐ Yes ☐ No If yes, when? _____

How did you hear about the program?_____

Describe any Major Disabilities or Health Problems:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Primary Physician's name:_____

Phone: (_____)_____Fax: (_____)_____

DENTAL INFORMATION

Describe your dental concerns:

How many natural teeth do you have remaining? # of Upper Teeth:_____ # of Lower Teeth:_____

Name of last dentist:_____ Phone: (_____)_____

Approximate date of last dental visit:_____

AGREEMENT

Agreement – Release of Information

a) I understand that I will need to provide personal information that includes but, is not limited to medical, dental, and financial condition. I authorize Horizon Dental Care to obtain information from, and share information with my physician(s), dentist(s), contact people I listed, and/or government or private agencies in order to determine my eligibility for the program.

b) I understand information provided by me or others as noted above may be given only to the volunteers involved in my treatment and will be held confidential.

Eligibility & Treatment Understanding

a) I realize that my application to the program does not assure I will be referred for an examination or that I will be accepted as a patient following an examination. I understand that Horizon Dental Care, which coordinates the program, will determine whether I am eligible for the program. I further understand that Dr. Johnson is solely responsible for diagnosis and any possible treatment that I might receive for my dental needs.

b) I understand that, if chosen, Horizon Dental Care has volunteered to treat my existing dental condition only and is not obligated to provide donated care in the future or to maintain me as a patient.

c) I understand that, if chosen, Horizon Dental Care may discontinue providing services to me at any time upon reasonable notice provided to me. I understand that, after receiving such notice, I am responsible for obtaining the services of an alternate dentist. I also understand that Horizon Dental Care has no responsibility to assist me in obtaining the services of an alternate dentist.

My Responsibilities

a) I agree to find and obtain reliable transportation to and from all dental appointments. Also, I agree to arrive on time to all of my appointments and will make every effort to arrive 15 minutes early prior to the time of my appointment.

b) I agree to keep all appointments unless I have a serious emergency and rescheduling is unavoidable. If I have an emergency and I am unable to keep an appointment, I will follow Horizon Dental Care's policy regarding cancellation and call the dentist's office to cancel my appointment at least 24-48 hours in advance. I understand that if I miss an appointment without calling in advance, reschedule or cancel more than one appointment, I may be terminated from the program.

To the best of my knowledge, the information provided in this application is a full and accurate disclosure of my current physical, medical, and dental health status and I agree to the terms and conditions stated above:

Signature of applicant or applicant's guardian (if applicable): _____

Printed name of applicant: _____ Date:_____/_____/_____