APPLICATION

PATIENT INFORMATION

Patient's Name: _____ Age: _____ Sex: _____

Birthdate: __/__/____ Social Security Number: _____ Email: _____

Home Address: _____

City, State: _____ Zip Code: _____ How long have you been at this address: _____

Home Phone: _____ School: _____ Grade: _____

Patient Hobbies: _____

General Dentist: _____ Dentist Phone Number: _____

How did you hear about The Gift of a Smile Program?: _____

PARENT OR GUARDIAN INFORMATION

Name: _____ Marital Status: _____ Email: _____

Home Address: _____ Own ( ) Rent ( )

City, State: _____ Zip Code: _____ How long have you been at this address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Birthdate: __/__/____ Relationship to patient: _____

Employer: _____ Occupation: _____

Household income (per year) :_____ How many live in your home? : _____

DENTAL INSURANCE INFORMATION

Does the applicant qualify for Medicaid or NC Health Choice? Yes ( ) No ( )

Is the applicant covered by dental insurance? (If yes, please specify insurance company name and policy) Yes ( ) No ( )

Insurance Company: _____ Policy #: _____

ADDITIONAL INFORMATION

Application submitted by: _____ Relationship to patient: _____

PLEASE INCLUDE:

*A **recent 5x7 head shot** photo of applicant with **full smile and teeth showing**.
*Please include a copy of last years W-2 form and
a copy of the most recent pay stubs for all family wage earners.

Please mail completed forms with picture and required materials to:

OP Smiles - The Gift of a Smile Program
373 Boone Heights Drive
Boone, NC 28607

For questions: opsmilesortho@gmail.com

Candidates will be asked to provide verification of family income insuring The Gift of a Smile Program that financial requirements are met. All applications, pictures, and supporting documents will NOT be returned and will become the property of OP Smiles.