Smiles Inc.

PO Box 248 * 107 E 10th St
South Pittsburg, TN 37380
Phone: (423) 228-3077 * Fax (423) 228-3332
Email: smilesfreedental@yahoo.com

DOCUMENTS NEEDED

- We need copies of income for **EVERYONE** in the household over the age of 18. This determines your poverty level guidelines for the household. If someone over the age of 18 does not have income they have to fill out the **zero income form**, signed by someone NOT in the family and have it notarized.
- Copy of Photo ID for the applicant.
- List **ALL** medications (including non-prescribed medicines) along with the dosage, strength and reason for taking each medicine.
- List all allergies.
- Copies of insurance cards
- Completed applications

APPOINTMENTS ARE MADE ON A FIRST COME, FIRST SERVED BASIS AFTER WE RECEIVE A COMPLETED APPLICATION WITH **ALL** DOCUMENTS. **Incomplete applications will not be accepted or held.**

You may turn in the application with copies of all required documents to Smiles on Tuesdays or Thursdays between 10 am – 4 pm or you may mail or fax to the above address or fax number.

Smiles is located at 107 E 10th street in the old National Guard Armory behind the Church of God next to Moss Motors.

SMILES, INC.

ADULT HEALTH QUESTIONAIRE

Last Name: _____ First Name: _____
DOB: _____Sex: M F Height:_____Weight:_____
Address:_____SS#:_____
City:_____State:_____Zip Code:_____
Home Phone #:_____Cell #:_____
Dental/Health Insurance: Y N If yes, name of company :_____(We need copy of insurance card)
Are you under a physician's care now? _____ If yes who and where: _____
Pharmacy you use:_____Phone:_____

Do you have, or have you had any of the following?	YES	NO	Please check Yes or NO for each condition.	YES	NO
High Blood Pressure -is it controlled -what does it usually run Excessive bleeding or bruising History of Blood Clots Stroke			Heart Issues such as: - Heart Attack - Angina - Pacemaker - Shortness of breath upon walking short distances - History of Bacterial endocarditis		
Diabetes -is it controlled -do you take insulin for it -what does you BS run			Lung Issues such as: - Asthma - COPD - Other		
Joint Issues such as: -Artificial joints -What joint - Arthritis rheumatoid - other			Tobacco Use if yes then: - For how long -Currently how many packs a day -Do you want help quitting		
Cancer -What type -When treated			Epilepsy/Seizures Depression Overly anxious		
Kidney Disease			Cold Sores		
Stomach/Intestinal Problems			Have you been addicted to pain medicines		
Liver Disease			Allergies to medicines		
Osteoporosis			Other Conditions you have not listed		
Thyroid Disease					
Panic attacks					
Pregnant					
Are you physically active?					

Patient name:_____ DOB:_____

Medicine	Dose	What is it for

In case of emergency who should we notify?_____
Relationship to patient:_____Phone #:_____
Do you give us permission to discuss medical or appointment information with above person? Yes No
May we leave medical and/or appointment information on your answering service? Yes No

Signature:_____Date:_____

Dentist Approval: _____ Date: _____

Changes	Dentist signed approval initials	Date

SMILES. INC.

PATIENT FINANCIAL INFORMATION

Applicant's Name:_____DOB:_____

Please list everybody in household: (Use back of page if necessary)

NAME	DOB	RELATION	**GROSS** MONTHLY INCOME
		self	

I, the undersigned, certify to the best of my knowledge that the above information is true and I authorize the verification of any and all information for the purpose of determining income eligibility for dental services provided by Smiles, Inc. I understand that I am subject to all applicable Federal and State laws concerning fraud if I knowingly give false or incomplete information to obtain services. I understand I have the right to appeal if my application is denied.

Signature:_____Date:_____

ATTACH COPIES OF PROOF OF INCOME

Income examples include gross wages, salaries, social security letter, pension annuities, veterans benefits, alimony, child support, military family allotments, self-employment, food stamps letter etc.

CONSENT FORMS

Please read and sign for all consents. Treatment will not be provided without all consents signed.

CONSENT FOR TREATMENT

I, the undersigned patient, hereby authorize and consent Smiles, Inc. to the operations, procedures, techniques and clinical photographs that the treating dentist(s) deem necessary for my care. I also hereby consent that any or all operations, procedures and techniques may be rendered by a student(s), resident(s), volunteer(s) or staff dentist of Smiles, Inc.

I understand that prior to any surgical or diagnostic procedure, technique, or taking of any clinical photograph, I will be advised by the treating dentist responsible for my care, and that I may ask questions concerning the treatment. I also understand that post-operative complications may be a normal consequence of the treatment rendered. I further understand that I may revoke this consent before such treatment is provided.

I attest that I have disclosed my health history information, including allergies, reactions to medicine, diseased, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.
I authorize the provider(s) and any other qualified assistants or medical professionals of Smiles, Inc. to perform the procedure(s) needed for my treatment. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures. I authorize any necessary life-saving procedures to be performed in the event of an emergency including a blood transfusion if necessary.

I understand that Smiles, Inc. depends on financial gifts from local businesses, churches, and individuals to provide affordable dental care to their patients. I understand this is a requirement of the clinic and part of the treatment provided. I give the clinic permission to take my photograph and use for administrative and fundraising purposes as they see fit.

I understand this consent will remain in force until I revoke it in writing. I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue. I have been given the opportunity to ask questions I might have and all questions have been answered in a satisfactory manner.

Patient signature:_____Date:_____

HIPPA and NOTICEE of PRIVATE PRACTICES and CONSENT

I hereby consent to the use and disclosure of my protected health information by Smiles, Inc. for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

- Smiles has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternate to the standard method of communication of my protected health information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Smiles, Inc. at the following address: PO Box 248, South Pittsburg, TN 37380
- I understand that while Smiles, Inc. may honor these requests, they are not required by law to do so.
- I am aware that Smiles, Inc. reserves the right to change the terms of their Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Smiles, Inc. will make available a revised Notice of Privacy Practice for my review.

Patient signature:_____Date:_____

PHOTO CONSENT

I understand that Smiles, Inc. depends on financial gifts from local business, churches, individuals and grants to provide affordable dental care to their patients. I understand this is a requirement of the clinic and part of the treatment provided. I give the clinic permission to take my photograph and use for administrative purposes as they see fit.

Patient signature:_____Date:_____

PATIENT NAME_____DOB_____

CONSENT FOR EXTRACTION OF TEETH

Please initial each paragraph after reading. If you have any questions, please ask ***BEFORE* initialing.

FOR TEETH TO BE EXTRACTED: _____

Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery, there are some risks. They include, but are not limited to, the following:

_____ 1. Swelling and/or bruising and discomfort in the surgery area.

_____2. Stretching of the corners of the mouth resulting in cracking or bruising.

_____3. Possible infection requiring additional treatment.

_____4. Dry Socket- Jaw pain beginning a few days after surgery usually requiring additional care. It is more common from lower extractions, especially wisdom teeth.

_____5. Possible damage to adjacent teeth, especially those with large fillings or crowns (caps).

_____6. Numbness, pain, or altered sensations in the teeth, gums, lip, tongue (including possible loss of taste sensation) and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or damaged. Almost always sensation returns to normal, but in rare cases, the loss may be permanent.

_____7. Trismus- Limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is a result of Jaw Joint Disorder (TMJ), especially when TMJ disease already exists.

_____8. Bleeding- Significant bleeding is not common, but persistent oozing can be expected for several hours

_____9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.

_____10. Incomplete removal of tooth fragments. To avoid injury to vital structures such as nerves or sinus, sometimes small root tips may be left in place.

_____11. Sinus Involvement. The roots of the upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth that may require additional care.

_____12. Jaw Fracture- While quite rare, it is possible in difficult or deeply impacted teeth.

I understand that services are provided by volunteer dental care providers and they are not administering care for or in expectation of compensation. I also understand that as volunteer dental care providers, the dentist, facility and all volunteers and any represented agents of Smiles, Inc. are immune from civil liability except for willful misconduct or gross negligence for any act or omission resulting in death, damage, or injury as long as the volunteers acts in good faith and within the scope of his or her duties within the organization providing dental care services.

Patient_____**Date**_____

Witness_____**Date** _____

Smiles, Inc.

Due to the extreme need for dental treatment and the number of patients needing treatment, broken appointments **will not be tolerated.**

- It is the responsibility of each patient to cancel appointment if they cannot come to a scheduled appointment.
- You must cancel your appointment twenty-four **(24)** hours before your appointment.
- If your appointment is not canceled 24 hours in advance it will be considered a broken appointment and you will have to wait 6 months before being put back on the waiting list.
- If you have 2 broken appointments you may be dismissed from our program.

I understand and agree to these terms.

Patient Name:_____ Date:_____

Signature:_____