1179 East Paris Ave. SE, Suite 220
Grand Rapids, MI 49546

winningsmiles@comcast.net PHONE: (616) 957-3977
www.winningsmilesortho.com FAX: (616) 575-9296

Application Checklist:

In order to be considered for the Winning Smiles Orthodontics Foundation program, **all** of the items below must be **fully** completed for **each** child that is applying to the program.

Please submit the fully completed application with ALL of the following documentation:

- ☐ **$30.00 nonrefundable application fee** (personal check, cashier's check or money order; made payable to Winning Smiles Orthodontics Foundation).
- ☐ Child's Application (page 2)
- ☐ Parent/Guardian Application (page 3)
- ☐ Notice of Privacy Practices (page 4 – MUST be signed by parent/guardian)
- ☐ Program Rules and Guidelines (page 5 – All items MUST be initialed by parent/guardian)
- ☐ Parent/Legal Guardian Consent & Child Consent (page 6 - MUST be signed by BOTH parent/guardian and child)
- ☐ General Dental Form (page 7 – MUST be completed by child's general dentist or dental hygienist based on an examination no more than six (6) months prior to the application date and show good dental hygiene and no unfilled cavities)
- ☐ Most recent Federal Tax Form (1040) and W-2's or SSI awards letter. For non-parental custodians, submit a copy of the authorization to make medical decisions. For children in state custody, submit a copy of their state medical card and medical consent.
  - If submitting a Form 1040, you must submit a complete copy of the tax return.
  - If the child is not claimed on your tax return, explain why and also submit the tax return for the person who claims the child along with proof of where the child resides (e.g. school records)
  - If you share joint custody, please include both parents' tax returns or SSI letters.
  - If you alternate claiming your child, please include both parents' tax returns.
  - **Proof of income is REQUIRED** in order to apply for braces through Winning Smiles Orthodontics Foundation in the form of either **Federal Tax Form 1040/1040A** OR a **SSI awards letter**. If your income level does not require you to file taxes, but you are legally allowed to file, you **must** do so in order to apply for our program, even if your income is $0.
- ☐ Personal essay from the child and/or letters of support detailing why the child wants/needs braces, how they feel their life might be improved as a result of treatment, etc. (*This is optional but encouraged*)

If any of these required items are incomplete or missing, your application will be denied upon receipt. Your application will be reconsidered by submitting the required documentation.

Send the COMPLETE application to the office location you wish to receive treatment at!

How did you hear about Winning Smiles Orthodontics Foundation? Please circle and name all that apply.

Internet/Search Engine ______________________________
TV/Radio ______________________________
Dentist ______________________________
Orthodontist ______________________________
Newspaper/Magazine
School/Clinic
Nurse/Counselor
Family/Friend
Other ____

WINNING SMILES
ORTHODONTICS FOUNDATION

Grand Rapids Location

1179 East Paris Ave. SE, Suite 220
Grand Rapids, MI 49546
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Winning Smiles Orthodontics Foundation is happy to provide this opportunity for your child to receive braces! This is an opportunity that many children do not receive.

All families applying for this program **must** follow all program rules and guidelines. If approved, you and your child **must** follow all instructions given by the orthodontist as well. **Our program covers orthodontics only.** Any dental cleanings, fillings, extractions or surgical needs, or any other dental needs are the financial responsibility of the participant's parents or legal guardians.

Program Qualifications and Guidelines:

- Applicants must be 10-17 years of age (Young adults 18-25 years of age may also use this application);
- Have no more than four (4) baby teeth;
- Have good dental hygiene (as certified by the child's general dentist);
- Have no unfilled cavities;
- Not be wearing braces currently;
- Have a total household income at or below 250% of the Federal Poverty Level; and
- Be willing to pay the $30.00 application fee, a $1000.00/$1300.00 nonrefundable program administration fee (per child) and the reduced orthodontic treatment fee.

How the application and approval process works:

1. Once **all** of the application documents have been received by Winning Smiles Orthodontics Foundation, the application will be reviewed to determine if the child qualifies for the program.
2. If the child does qualify for the program, then the child will be scheduled for an initial orthodontic screening. The waiting period for a screening may take from 6 weeks to several months depending on demand.
3. The family will be notified at the screening whether the child (1) is approved for the program, (2) is declined for the program or (3) will need to be re-screened (due to poor dental hygiene, dental development, or other potential issues).
4. Upon acceptance, **the family must pay a nonrefundable program administration fee of $1000.00/$1300.00 to our office within 30 days in order to schedule the child's next appointment and begin treatment**. If this fee is not received by Winning Smiles Orthodontics Foundation within 30 days of notification, your child will be placed at the end of the waiting list. Fees are only guaranteed for 30 days following acceptance into the Foundation and are subject to change.

What if the application is declined?

- Winning Smiles Orthodontics Foundation will provide orthodontic treatment to anyone in need of these services. If the applicant does not qualify for this program, he/she will be evaluated for our other programs on a case-by-case basis

WINNING SMILES
ORTHODONTICS FOUNDATION

Child's Application (to be completed by the child; please write clearly) Today's Date ______________

Child's Last Name ______________ Child's First Name ______________ Middle Initial ______________

Date of Birth ______________ Social Security Number ______________ Gender ______________ Race/Ethnicity ______________

Street Address ______________ City ______________ State ______________ ZIP ______________ County ______________

Phone Number ______________ Email ______________

Name of School ______________ Grade ______________ School City, State ______________ Grade Point Avg. ______________

Hobbies/Interests ______________

Please describe why you want orthodontic treatment:

____

How did you become aware that you needed braces? ____

____

Below are some of the reasons why people get braces. Circle the ones that apply to you.

I am embarrassed how my teeth look.	A lot	A little	Not at all
I have difficulty eating and/or drinking.	A lot	A little	Not at all
I have pain in my mouth and/or jaw.	A lot	A little	Not at all
People make fun of my teeth.	A lot	A little	Not at all
I have difficulty talking.	A lot	A little	Not at all
I'm afraid to smile.	A lot	A little	Not at all
I cannot clean my teeth very well.	A lot	A little	Not at all
I cover my mouth when I talk or smile.	A lot	A little	Not at all

If anyone has ever made fun of your mouth or teeth, please give us examples of what people have said:
____

____

How do you think your life will change once you get braces? ____

____

If you are over 17, what are your plans for the next 2-3 years? Are you planning to move away from your current area? ____

____

WINNING SMILES
ORTHODONTICS FOUNDATION

Parent/Guardian Application (To be completed by parent/guardian; please write clearly)

______________________________ ______________ ______________
Parent/Guardian Last Name, First Name | Home Phone | Cell Phone

______________________________ ______________
Street Address | City | State | ZIP | Email

Child Lives With: ______________________ Relationship to Child: ______________________

Marital Status: ____________________ Spouse/Partner's Name: ______________________

If Divorced/Separated do you have sole or joint custody? ______________________
Please list all members in the household (family and non-family) and their relationship to the patient:

____

II. FINANCIAL – Acceptance into the program requires approved families to pay a **nonrefundable** program administration fee of $1000.00/$1300.00 and the reduced orthodontic treatment fee in monthly payments. If approved, your child can be scheduled to start treatment after the program administration fee is received at our office.

Do you receive Child Support? Yes/No What is the monthly child support benefit? _________
Are you currently employed? Yes/No Employer: ______________________ Do you receive SSI? Yes/No
Is your spouse/partner currently employed? Yes/No Employer: ____________ Do they receive SSI? Yes/No
Do any children in the household receive SSI? Yes/No Please list all Names and Amounts: ____________

____
Do any non-family members in the household contribute to the household income? Yes/No Amount: ________

Do you own or rent your home? ________________ Number of years at this address:

How many people are in the child's household? ______ Family income from ALL sources per year: ___________

You must submit your most recent IRS tax return and W-2's or a copy of your SSI benefit awards letter(s) from ALL members in the household receiving benefits. If the child is not claimed on your tax return, please explain why and submit the tax return for where the child lives with proof the child is living at that address (e.g. school records). For non- parental guardians, please submit a copy of your medical authorization. For children in state custody, please submit a copy of their state medical card and consent. **If you do not file income taxes or receive SSI benefits, your application will not be approved.**

III. GENERAL INFORMATION Is the child currently wearing braces? Circle one: Yes No
(If the child is currently wearing braces your application will not be approved)

Have any of the child's family members been treated through Winning Smiles Orthodontics Foundation? If yes, please list their name(s) ____

Who will be bringing the child to his/her orthodontic appointments? ______________________
Please list any health issues we should be aware of: ______________________
Why do you want your child to receive orthodontic treatment? ______________________

____

Any other information about the child you wish to bring to our attention?

____

IV. INSURANCE INFORMATION Is the child covered by Medicaid? Yes No
Is the child covered by dental insurance? Yes No Is there an orthodontic benefit? Yes No

______________________ ______________________ ______________
Name of Carrier | Amount of Coverage | ID Number

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures – Effective Date: This notice is effective on or after 06/30/2008.

Treatment: Your health information may be used by staff members, volunteers, agents and board members and disclosed to other health care professionals for the purpose of evaluating your application and providing your treatment.

Program Operations: Patient information, including first name, case history and photographic images may be used as necessary to support assessment, public relations, fund development and other activities of Winning Smiles Orthodontics Foundation.

Law enforcement: Your health information may be disclosed to law enforcement agencies, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights: You have certain rights under the federal privacy standards. These include: ▪ The right to request restrictions on the use and disclosure of your protected health information ▪ The right to inspect and copy your protected health information ▪ The right to amend or submit corrections to your protected health information ▪ The right to receive an accounting of how and to whom your protected health information has been disclosed ▪ The right to receive a printed copy of this notice.

Winning Smiles Orthodontics Foundation Duties: We are required by law, and by the privacy policies and practices that are outlined in this notice, to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information: You may generally inspect or copy the protected health information we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office.

Complaints Contact Person: If you would like to submit a complaint or have questions regarding our privacy practices, you may contact us in writing at the following address: Dennis E. Winn II, DDS, MSD, Winning Smiles Orthodontics Foundation, 1179 East Paris Ave. SE, Suite 220, Grand Rapids, MI 49546. You will not be penalized or otherwise retaliated against for filing a complaint.

I, ____ have received a copy of Winning Smiles Orthodontics Foundations' Privacy Practices.
Custodial Parent or Legal Guardian Printed Name

____ ____________________________
Custodial Parent or Legal Guardian Signature Date (mm/dd/yyyy)

WINNING SMILES
ORTHODONTICS FOUNDATION

Program Rules and Guidelines

This opportunity for your child to receive braces through Winning Smiles Orthodontics Foundation is one that we are very happy to provide and one that many children do not receive. However, we only provide treatment if you and your child fully cooperate with the treatment plan and the treating orthodontist. All the following conditions must be met to be eligible to start treatment and to continue treatment.

PARENT OR GUARDIAN; PLEASE READ CAREFULLY AND INITIAL EACH ITEM:

_________ 1. Winning Smiles Orthodontics Foundation provides for orthodontic treatment ONLY. Extractions, cleanings, oral surgery or other treatment that may be necessary before, during or after orthodontic treatment are the financial responsibility of the child's parents or legal guardians.

_________ 2. Your child must have been seen by a dentist within six (6) months of the date on this application. Your child's dentist must complete the Dental Referral Form and indicate that all necessary treatment has been completed before braces will be applied. Your child must have regular dental visits and cleanings at least every six months during orthodontic treatment. If your child has cavities or periodontal disease, these conditions must be completely remedied before treatment is started.

_________ 3. If accepted, the parents/legal guardians of the child agree to submit the **nonrefundable** program administration fee of $1000.00/$1300.00 upon notice of acceptance. If payment is not received within 30 days of notice, your child will go back on a waiting list. Fees are only guaranteed for 30 days and are subject to change.

_________ 4. Once accepted and the program fee is received, you will also be responsible for the balance of the reduced cost of orthodontic care as determined by the program. Without this discount, the average cost of braces is typically $5,500.

_________ 5. You and your child must fully follow the treatment plan set by your orthodontist, which will be explained to you before treatment starts. If you fail to follow the treatment plan, the treating orthodontist has the option to refuse to continue treatment by removing the braces and ending treatment.

_________ 6. If you have to move before treatment concludes, please tell your orthodontist as soon as possible. You are responsible for making any arrangements necessary to complete your child's care. Your options are to either have your current orthodontist remove the braces or you will need to find a new orthodontist in your new community. The new treating orthodontist will have their own separate treatment fee and Winning Smiles Orthodontics Foundation is not responsible for locating a new orthodontist or paying for continued treatment.

_________ 7. During the course of treatment, if your child's teeth are not cleaned properly, cavities can form around the braces. If your child does not keep his or her teeth, gums and mouth clean, or if cavities form and are not remedied, the orthodontist has the option to remove the braces and end treatment. Your child will then be dismissed from the program.

_________ 8. Regular orthodontic appointments are required to make sure teeth move as expected and no unwanted movement occurs. It is your responsibility to make sure that all scheduled appointments are kept. Failure to meet this obligation of attending appointments on a regular basis is grounds for the orthodontist to remove the braces and end treatment.

_________ 9. During the course of treatment, your child must cooperate with the orthodontist. Failure to fully cooperate with the orthodontist, or to maintain proper behavior so that the treatment can be delivered, can result in the orthodontist refusing to continue treatment until the behavior problem is corrected or removing the braces.

_________ 10. Broken appliances or loose brackets and bands can cause damage to teeth and the rest of the mouth. Your child must take special care not to eat hard or sticky foods or pull on the braces. If there is frequent damage to the braces, the orthodontist has the option of removing the braces or charging you to repair the damage, which is not covered by this program.

_________ 11. One upper and/or one lower retainer device will be provided as part of the treatment program at no charge. If this retainer is lost or damaged, you will be charged for a replacement.

_________ 12. If your child is accepted into the program, you consent to Winning Smiles Orthodontics Foundation's use, without charge, of all photos, video or audio recordings of your child, first name, statements and biographic or other information concerning his/her participation in the program, for fundraising or other promotional and advertising purposes and expressly waive any benefit derived from such use.

Consent and Hold Harmless Agreement

The undersigned has read, understands and agrees to abide by the attached **Program Rules and Guidelines** for receiving orthodontic treatment through **Winning Smiles Orthodontics Foundation** and has been given the opportunity to ask questions about this information. If our application is approved, I consent to allow Winning Smiles Orthodontics Foundation and its orthodontists to provide orthodontic treatment for my child. I understand that acceptance into the Winning Smiles Orthodontics Foundation program for my child's orthodontic care is based on our (my child's and my) ability to maintain my child's dental health as indicated in the Program Rules and Guidelines and to abide by all the Program Rules and Guidelines. **I also understand that if we do not maintain dental health and abide by the Program Rules and Guidelines, the braces will be removed and treatment will be terminated with no refund.** I further agree that if treatment is stopped and my child is removed from the program for not following the Rules and Guidelines, or for any other reason, we (my child and I) will hold Winning Smiles Orthodontics Foundation, Dennis E. Winn II, DDS, MSD and any other treating orthodontist harmless and free from any liability for any damage or injury resulting from the termination of said treatment.

I, on behalf of myself and my child, acknowledge that Winning Smiles Orthodontics Foundation does not itself provide the orthodontic treatment and that all treatment will be provided by an assigned orthodontist (employee). In consideration of the acceptance of my child's application to Winning Smiles Orthodontics Foundation, we (my child and I) release Winning Smiles Orthodontics Foundation, the orthodontist and their agents, representatives, and successors from any and all claims, demands, actions, proceedings or liability of any kind whatsoever that we may have at any time arising, directly or indirectly, from (1) our participation in the Winning Smiles Orthodontics Foundation program, or (2) any action taken by Winning Smiles Orthodontics Foundation or its orthodontists based on the Program Rules and Guidelines. I further acknowledge and understand that Winning Smiles Orthodontics Foundation and its orthodontists do not guarantee satisfaction with the outcome of the orthodontic treatment provided. This Agreement shall be interpreted and enforced in accordance with the laws of the state of Michigan and is intended to be as broad and inclusive as permitted by the laws thereof. Waiver of any provision by Winning Smiles Orthodontics Foundation shall not operate or be construed as a continuing waiver. This Agreement shall survive termination or completion of my child's treatment. If any portion of this agreement is held invalid, the remainder of it shall remain effective.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ, UNDERSTAND AND VOLUNTARILY AGREE TO THE ABOVE CONSENT AND HOLD HARMLESS AGREEMENT.

Custodial Parent or Legal Guardian Consent: I further certify I am the custodial parent or legal guardian for the child named below, that all the information enclosed in this application is true and correct and that all income is reported. I understand that deliberate misrepresentation will not be tolerated and will result in dismissal from the program. Your signature must be hand written. Electronic signatures are not acceptable.

Date (mm/dd/yyyy)	Custodial Parent or Legal Guardian Signature	Printed Name

Child's Consent: (Child MUST sign even if under 18 years of age)

Date (mm/dd/yyyy)	Child/Applicant Signature (Not Parent/Guardian)	Printed Name

PATIENT NAME____ Common Name________________
Hobbies/Sports/Musical Instruments____
Date of **BIRTH** _________/__________/____________Age _________ Male (______) Female (______)
Responsible Party__________________________ Relationship to Patient_____________________
Address____Zip Code________________
Phone #: Home (_____)______-_________ Work (_____)______-_________ Cell(_____)______-_________

Would you like us to text, e-mail, and/or call with your appointment reminders? TEXT EMAIL CALL
E-Mail Address ____@__________________.________
Additional E-Mail Address ___________________________________@__________________.________
Cell Phone # *(for text)*(_______)_______-__________ Phone # *(for calls)* (_______)_______-__________

If patient is a Minor please continue – Adult patients may skip down to the Insurance Information if any or the Dental History
Mothers Name ____ Phone #(_____)______-_________
Single ☐ Married ☐ Divorced ☐Deceased (If Applicable) Stepfathers Name ____________________________
Address if different from above____
Employer __________________________________Occupation _________________________________
Fathers Name ____ Phone #(_____)______-_________
Single ☐ Married ☐ Divorced ☐Deceased (If Applicable) Stepmothers Name ___________________________
Address if different from above____
Employer __________________________________Occupation _________________________________

How did you hear about us? ____
Name of Person(s)-(other than parents) who may be accompanying the patient for the appointments:
____Relationship to Patient _____________________
What information are we able to give to this person: NONE FINANCIAL TREATMENT ANY *(circle one)*

ORTHODONTIC INSURANCE INFORMATION

(Only needed if there is orthodontic coverage)

Primary Insurance _______________________________________ *Orthodontic Coverage? YES/NO* __________
Name of Insured__________________________________ Relationship to Patient____________________
Birth date_____/_____/______ SS#_______-_______-_________ Employers Phone # (_______) _______-_________
Name of Employer________________________ Insurance Company______________________________
Group # ______________________________ Policy#_____________________________________
Address____ Phone # (_______) _______-_________

Secondary Insurance _____________________________________ *Orthodontic Coverage? YES/NO* __________
Name of Insured__________________________________ Relationship to Patient____________________
Birth date_____/_____/______ SS#_______-_______-_________ Employers Phone # (_______) _______-_________
Name of Employer________________________ Insurance Company______________________________
Group # ______________________________ Policy#_____________________________________
Address____ Phone # (_______) _______-_________

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my/my child's medical/personal status. I also authorize the dental staff to perform the necessary dental services I/my child may need during treatment.

____/________/_______
Signature (Patient or Parent/Guardian) **Date**

WINNING SMILES
ORTHODONTICS FOUNDATION

DENTAL HISTORY

Name of Dentist____ Phone # (_______)_______-_________
Address____ Date of last Cleaning_____/_____/_____
What are your main concerns you would like the orthodontist to accomplish? ________________________________
____

Y/N – Clenching/Grinding
Y/N – Thumb/Finger Sucking
Y/N – Nursing/Bottle/Pacifier Habits
Y/N – Do you still have you wisdom teeth
Y/N – Have you ever taken Fosamax or any other bisphosphonate
Y/N – Has your child been evaluated or had orthodontic care before
Y/N – Are you aware of any missing or extra permanent teeth
Y/N – Have there been any injuries to the face, mouth, teeth or chin
Y/N – Has there even been any pain/tenderness in the jaw joint (TMJ/TMD)

Y/N – Lip Sucking/Biting
Y/N – Tongue Thrust
Y/N – Do you floss daily
Y/N – Do you brush daily
Y/N – Mouth Breather
Y/N – Nail Biting
Y/N – Speech Problems
Y/N – Any Tobacco Use
Y/N – Ever taken Phen-Fen

MEDICAL HISTORY

Name of personal physician__________________________________ Phone # (_______)_______-_________
Date of last visit_______/_______/_______ Your current physical health is: Good ☐ Fair ☐ Poor ☐
Have Adenoids/Tonsils been removed? Y/N Has Puberty Begun? Y/N Girls-Has Mensruation Begun? Y/N
Please list any medications/drugs you are taking:____
Any medical conditions we should be aware of: ____

Have you had any of the following diseases or medical problems?

Y/N – Abdominal Bleeding/Hemophilia
Y/N – ADD/ADHD
Y/N – AIDS/HIV+
Y/N – Alcohol/Drug Abuse
Y/N – Anemia
Y/N – Any Hospital Stays/Operations
Y/N – Arthritis
Y/N – Artificial Bones/Joints/Valves
Y/N – Asthma
Y/N – Blood Transfusion
Y/N – Cancer/Chemotherapy/Radiation
Y/N – Colitus/Ulcers
Y/N – Congenital Heart Defect
Y/N – Diabetes

Y/N – Difficulty Breathing
Y/N – Emphysema
Y/N – Epilepsy/Seizures/Fainting
Y/N – Frequent Headaches
Y/N – Glaucoma
Y/N – Handicaps/Disabilities
Y/N – Hay Fever
Y/N – Hearing Impairment
Y/N – Heart Attack/Surgery
Y/N – Heart Murmur
Y/N – Hepatitis
Y/N – Herpes/Fever Blisters
Y/N – High/Low Blood Pressure
Y/N – Kidney/Liver Problems

Y/N – Lupus
Y/N – Mitral Valve Prolapse
Y/N – Psychiatric Problems
Y/N – Rheumatic Problems
Y/N – Scarlet Fever
Y/N – Shingles
Y/N – Sickle Cell Disease/Traits
Y/N – Sinus Problems
Y/N – Stroke
Y/N – Tuberculosis
Y/N – Venereal Disease
Y/N – Other(please explain)
____
____

Are you allergic to any of the following?

Y/N – Aspirin
Y/N – Codeine
Y/N – Latex
Y/N – Penicillin
Y/N – Dental Anesthetic
Y/N – Tetracycline
Y/N – Plastics
Y/N – Erythomycin
Y/N – Any Type of Metal/Nickel ______________________ Y/N – Other (please explain) ______________________

For Women Only

Y/N – Are you Pregnant (Week#: ______) Y/N – Are you Nursing Y/N – Are you taking Birth Control

____ _______/_______/________
Signature (Patient or Parent/Guardian) **Date**

____ _______/_______/________
Signature (Orthodontist) **Date**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT (If Patient is a Minor – Responsible Party Information)

Name: ____

Address: ____

Telephone #: ____ E-mail: ____

Patient #: ____Social Security #: ____

PATIENTS NAME:____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read out Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of you protected health information, and of other important matters about your protected health information. A copy of out Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of out Notice, at any time by contacting:

Contact Person: The Office of Dennis E. Winn II____

Telephone: (616) 957-3977____

Address: 1179 East Paris Ave. SE, Suite 220, Grand Rapids, MI 49546____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and siclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____ Date: ____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

YOU ARE ENTITLES TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activites, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ Date: ____

GENERAL DENTAL FORM
(Must be FULLY completed by your general dentist or dental hygienist.)

Dear Dental Care Provider,

Your patient is applying to the Winning Smiles Orthodontics Foundation program with the hope of receiving braces at a significantly discounted cost. As this child's dental care provider, you play an important role in the application process by filling out the Dental Referral Form which helps us determine whether or not a patient is a good candidate for our program.

Thank you very much for taking the time to provide us with this important information.

Date of the most recent visit – must be within 6 months of application: ___________________________

How long has he/she been your patient? _______________

Patient Name____
(First) (MI) (Last)

Dentist Name: ____
(First) (Last)

Dentist Address: ____
(Street) (City) (State) (ZIP Code)

Dentist Phone Number*: _________________________ Dentist Email: _________________________________
*Important for verification purposes

Dentist Fax #: ________________________

This section is REQUIRED. Application will not be considered if this section is not FULLY completed.

Does this child have good oral hygiene? ☐ Yes ☐ No (Yes or No response ONLY)		Caries Free: ☐ Yes ☐ No	Physically capable of cleaning teeth: ☐ Yes ☐ No
Positive attitude toward dental care: ☐ Yes ☐ No		Keeps appointments: ☐ Yes ☐ No	Patient motivated/interested in orthodontic treatment: ☐ Yes ☐ No
Impacted teeth: ☐ Yes ☐ No	Missing Teeth: ☐ Yes ☐ No	Have second molars erupted? ☐ Yes ☐ No	Number of deciduous teeth present: __________

Other Functional or Aesthetic Problems/Comments:____

____

Does this patient need restorative work at this time? ☐ **Yes** ☐ **No**
Is an appointment scheduled at this time for restorative work? ☐ **Yes** ☐ **No**
What is the date of this appointment: ___________________
(**The child MUST have restorative work completed <u>before</u> submitting this application.** The application will NOT be considered if the child has caries.)

____ ____
Dentist Signature Date Signed
(Please attach a business card for verification)

YOU MUST INCLUDE THIS COMPLETED FORM WITH YOUR APPLICATION PACKAGE