Smiles Change Lives

Program Guidelines and Application

The Jones Foundation and Smiles Change Lives (SCL) are happy to provide this **once in a lifetime 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. By fully complying with all program rules and guidelines, and all instructions given by the orthodontist, your child will be rewarded with better confidence and a brilliant smile.

QUALIFICATIONS: Your child must meet ALL qualifications to apply to the program.

- Be up to, but not including, 19 years of age
- Have "good" dental hygiene (*as certified by the child's general dentist within 30 days of application date*)
- Have no unfilled cavities
- Have a moderate to severe need for braces;
- Not be wearing braces currently; nor ever have received braces from the Jones Foundation previously
- Have a total household income at or below 200% of the Federal Poverty Level (*see page 4 for more information*)
  - 200% of the Federal Poverty Level can be determined by visiting http://www.smileschangelives.org/the-jones-foundation
- Be a U.S. citizen (proof of U.S. citizenship MUST be included) who has resided in **Coffey, Lyon, or Osage counties in Kansas** continuously for the past 12 months and will continue to reside in one of these counties for the entire term of treatment
- Be willing to pay the **non-refundable $30 (USD) application fee** and **the non-refundable $650 (USD) Required Financial Investment (per child)**

APPLICATION PROCESS:

- Upon receipt of a **COMPLETE** application, the application will be reviewed and the family will be notified whether or not the child qualifies for the next step in the application process. **If your application is INCOMPLETE**, it will be returned to you and in order to be considered for the program, **you will be required to submit a NEW complete application, including an additional $30 (USD) non-refundable fee**.
- If your child qualifies for the program, the family will receive a letter indicating when, where and how to schedule the screening appointment. *(The screening orthodontist may or may not be the same orthodontist to treat your child if your child is accepted for treatment.)*
- Once SCL has received a complete application, it will be reviewed by the SCL Review Panel and the family will be notified whether the child (i) is qualified for the program and will placed on a wait list, (ii) is declined for the program, or (iii) will need further evaluation (due to poor oral hygiene, dental development, or other potential issues).
- If your child is approved for the program, the family must submit the **$650 (USD) Required Financial Investment** to SCL **within 30 days**. We cannot accept partial payments. We cannot accept payment from a Flexible Spending Account or Health Savings Account. If this fee is not received by SCL in full within 30 days of notification, your child will lose his/her placement in the JF/SCL program and will need to reapply with a NEW application. This financial contribution is your investment in your child's beautiful new smile. Likewise, when you pay the Required Financial Investment, you know that not only will your child benefit, but that you are also "paying it forward" to help the program be available to assist other families in the future.
- If the payment is received within 30 days, the applicant will be assigned to a Jones Foundation/SCL orthodontist and will be on their way to a healthy, happy smile!

APPLICATION CHECKLIST

(Must be signed and included with submitted application)

All of the items below must be fully completed and submitted to SCL for EACH child that is applying to the program. Use the checklist to indicate that you have included each required document; that each has been fully completed; and that all items are signed where required. **If your application is INCOMPLETE, it will be returned to you and in order to be considered for the program, you will be required to submit a NEW complete application, including an additional $30 non-refundable fee.**

- ☐ **$30.00 (USD) non-refundable application fee** (check or money order; payable to *Smiles Change Lives*)
- ☐ **Copy of child's birth certificate or United States passport** (proof of U.S. citizenship MUST be included)
- ☐ **General Application** (pg 3-4)
- ☐ **Child's Application** (pg 5)
- ☐ **Notice of Privacy Practices** (pg. 6 – MUST be signed by parent/guardian)
- ☐ **Program Rules and Guidelines** (pgs. 7 - All items MUST be ***initialed*** by parent/guardian)
- ☐ **Parent/Legal Guardian Consent** & **Hold Harmless** (pg. 8–MUST be signed by BOTH parent/guardian & child)
- ☐ **Dental Referral Form** (pgs. 9-10 - Must be FULLY completed by child's dentist or dental hygienist based on an exam no more than 30 days prior to the application date and show good dental hygiene and no unfilled cavities)
- ☐ **Federal Tax Form 1040**: Proof of income MUST be submitted in the form of a COMPLETE copy of the most recent year's federal tax return (include ALL pages, schedules or statements)**.** Tax forms that are altered in any way, including removing/blacking out Social Security numbers, **will NOT be accepted**. **If you are submitting applications for more than one child, you MUST include a copy of your tax form with EACH application.** ***See page 4 for additional information on this requirement.***
- ☐ **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 strongly encouraged)*

_____

Signature of parent/guardian

Mail COMPLETE application to: **Smiles Change Lives, 2405 Grand Blvd, Suite 300, Kansas City, MO 64108**

Please ensure you use adequate postage *and keep a copy of your completed application for your records.*

GENERAL APPLICATION

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

I. CHILD'S PERSONAL INFORMATION

Child's **Legal** Last Name _____ Child's **Legal** First Name _____ Middle Initial _____ Child's Nickname (if any) _____

Child's Date of Birth _____ Social Security Number _____ - _____ - _____ Gender _____

Street Address _____ City _____ State _____ Zip _____

County _____ Phone Number _____ Email (REQUIRED) _____

Name of School _____ Grade _____ School City, State _____

II. PARENT/GUARDIAN'S PERSONAL INFORMATION

Parent/Guardian Last Name _____ First Name _____ Relationship to Child _____

Home Phone _____ Cell Phone _____ Email **(required)** _____

Address _____ City _____ State _____ Zip _____

Marital Status: _____ Spouse/Partner's Name: _____ Relationship to Child: _____

Spouse/Partner Phone: _____ Email: _____

If child doesn't live with both parents, name of non-custodial parent: _____

III. OTHER INFORMATION

Have any of the child's family members applied to or been treated through JF/SCL? If yes, please list their name(s):
_____

How will the child get to his/her orthodontic appointments? _____

How far are you willing to travel for treatment (we attempt to place children as close as possible, but search up to a 100 mile radius for available treatment providers)? _____

Please list any health issues your child has that we should be aware of: _____

Are you or any member of your immediate family currently wearing Invisalign? □ Yes □ No Metal Braces? □ Yes □ No

Name of family member(s) and relationship to child: _____

Name/Address of treating orthodontist: _____

GENERAL APPLICATION CONT.

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

IV. FINANCIAL: Qualification requires an adjusted gross income **at or below** 200% of the Federal Poverty Level for the most recent tax year.

You **MUST** submit a copy of your most recent **Federal Tax Form 1040**. If you do not file Form 1040, your application will NOT be approved. We DO NOT accept any other type of proof of income. Tax forms that are altered in any way, including removing/blacking out Social Security numbers, **will NOT be accepted**. **If you are submitting applications for more than one child, you MUST include a copy of your tax form with EACH application.**

If submitting Form 1040, please note:

- Line 7 of Form 1040 must show adjusted gross income at or below 200% of the Federal Poverty Level.
- The child applying MUST be listed as a dependent on either page one of Form 1040 or on an additional statement of dependents along with the child's Social Security number. *For purposes of determining financial qualification, your adjusted gross income on line 7 of Form 1040 and the number of people listed on your tax return will be used so be sure that all pages of the tax return listing dependents are included.*
- If the child is NOT claimed as a dependent on your tax return, you must explain why and ALSO submit the tax return for the person who DOES claim the child, as well as proof of where the child resides (e.g. school records). In this situation, BOTH tax returns must be submitted and each must separately meet our income qualifications.
- If the child lives with both parents, and a joint return is not filed, the separate tax returns of BOTH parents must be submitted to show total household income. In this situation, the total adjusted gross income of both parents combined must meet our income qualifications.
- Even if your income level doesn't require you to file taxes, you must do so to apply to our program, even if your income is $0.

If the child applying is not claimed as a dependent on your tax return, you must explain why and submit the tax return for the person who DOES claim the child, as well as proof of where the child resides (e.g. school records). _____

V. INSURANCE INFORMATION: *This information is **not** a factor in determining eligibility*

Is child covered by Medicaid/State Program? ☐ Yes ☐ No Is child covered by dental insurance? ☐ Yes ☐ No

Is there an orthodontic benefit? ☐ Yes ☐ No

_____	_____	_____
Name of Carrier	*Amount of Coverage*	*ID Number*

VI. HOW DID YOU HEAR ABOUT SMILES CHANGE LIVES/JF? Please include details where possible.

_____Web search- what words or phrases did you search? _____
_____ Website- name of site or organization _____
_____ Family/Friend-name _____
_____ SCL Current Participant Referral-name_____
_____ Dentist (your regular dentist)-name/location _____
_____ Dental school/clinic-name/location _____
_____ Orthodontist-name/location_____
_____ Newspaper/magazine-publication name _____ date _____
_____ TV/Radio-station name _____ date _____
_____ Event (example: health fair) please describe _____ date _____
_____ Other-please describe _____

Please be as detailed as possible when filling out the information below as this information helps us determine your need for braces. This will be sent to our providers and National Review Panel for consideration for our program.

CHILD'S APPLICATION

(To be completed by the child; please write clearly)

Child's Name: _____

Are you currently wearing braces? ☐ Yes ☐ No

Below are some of the reasons why people get braces. Select all that apply to you.

I am embarrassed by 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 when you get braces? _____

_____

What are your plans for the next 2-3 years? Are you planning to move away from your current area?

_____

_____

Is there anything else you would like to share with us? (hobbies, school activities, music, sports, etc.)

_____

_____

Why is it important for you to get braces? Why do you want/need braces? (Be as detailed as possible and use extra paper if necessary)

_____

_____

_____

_____

_____

_____

_____

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

Treatment: Your protected health information may be used by staff members, volunteers, agents and national and advisory board members of the Virginia Brown Community Orthodontic Partnership d/b/a Smiles Change Lives and the Walter S. & Evan C. Jones Foundation and disclosed to other health care professionals, including but not limited to your assigned screening and treatment provider(s), 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 Smiles Change Lives.

Law enforcement: Your protected 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 protected 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 protected 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 noticed us of your decision to revoke your authorization.

Individual Rights: You have certain rights under the federal privacy standards. These include: The right to get an electronic or paper copy of your record ▪ The right to request confidential communications ▪ 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 ▪ The right to file a complaint.

Smiles Change Lives Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice and to notify you when a breach of your unsecured protected health information has occurred.

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 SCL at the address below.

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: Smiles Change Lives, 2405 Grand Blvd, Suite 300, Kansas City, MO 64108, or you may also contact the Secretary of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date: This notice is effective on or after 05/01/2005.

I, _____ have received a copy of Jones Foundation/Smiles Change Lives' Privacy Practices.
Custodial Parent or Legal Guardian **PRINTED NAME**

_____ _____
Custodial Parent or Legal Guardian **SIGNATURE** Date (mm/dd/yyyy)

Program Rules and Guidelines

Jones Foundation/Smiles Change Lives (JF/SCL) are happy to provide this **once-in-a-lifetime** opportunity for your child to receive braces. However, we will only provide treatment if you and your child fully cooperate with the treatment provider and his/her treatment plan. All of the following conditions must be met to be eligible to start treatment and to continue treatment. **PARENT/GUARDIAN: PLEASE READ CAREFULLY AND INITIAL EACH ITEM.**

_____ 1. You must be a US citizen and reside in Coffey, Lyon or Osage County, KS and have continuously done so for the prior year. You must continue living in one of these counties during treatment. Failure to do so will result in removal from the program.

_____ 2. This program provides orthodontic treatment ONLY. Parents may request financial assistance with extractions, cleanings, oral surgery or other treatment needed before, during or after orthodontic treatment from the JF, which may be approved at the sole discretion of the JF.

_____ 3. Your child must have been seen by a dentist within **30 days** of the date of receipt of his/her 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. If your child has cavities or periodontal disease, these conditions must be completely remedied before treatment is started. Your child must have regular dental visits/cleanings at least every six months during orthodontic treatment. During the course of treatment, if your child's teeth are not cleaned properly, cavities can form around the braces. Your child may be removed from the program at any time due to poor dental hygiene.

_____ 4. Once a treatment provider is located, the parents/guardians agree to submit a non-refundable **$650 (USD)** Required Financial Investment upon notice from SCL. If payment is not received within **30 days** of notice, your child will lose his/her placement in the program and must reapply. We cannot accept payments from Flexible Spending Accounts or Health Savings Accounts.

_____ 5. Once accepted and the Required Financial Investment is received, your child will begin treatment with the assigned SCL/JF treatment provider. Treatment is only available from the assigned provider, who is donating his/her time and all materials/supplies required to provide full treatment for your child. Typically, the average cost of braces NOT acquired via SCL/JF is $6,000. Note: once the $650 payment is received, it is non-refundable and will not be returned if your child is removed from the program in accordance with the program rules and guidelines.

_____ 6. Regular appointments are required to make sure teeth move as expected and no unwanted movement occurs. Since the treatment provider is donating the treatment, s/he may require you to attend appointments during non-peak hours. As a result, your child's appointments will likely be scheduled during the mid-morning or mid-afternoon hours. It is your responsibility to make sure that all scheduled appointments are kept. If you must cancel or reschedule an appointment, you are required to give your doctor at least 24 hours notice. **Not calling to cancel or missing an appointment is grounds to remove your child from the program and have your child's braces removed**.

_____ 7. You and your child must fully follow the treatment plan set by your treatment provider, which will be explained to you before treatment starts. If you fail to follow the treatment plan, including but not limited to proper use of bands, appliances, and retainers, the treatment provider has the option to refuse to continue treatment and to remove braces.

_____ 8. If you move before treatment concludes, please call us in addition to telling your treatment provider. You will be removed from the program and will be responsible for making any arrangements necessary to complete your child's care. Your options are to either have your current treatment provider remove the braces or you will need to find a new treatment provider in your new community for which you will be financially responsible. SCL/JF is not responsible for locating a new treatment provider or paying for continued treatment.

_____ 9. Providers accept your child for treatment based upon your child's qualification for the SCL/JF program, both in terms of orthodontic and financial need. As such, it is important that you treat the provider and his/her staff with respect, express your gratitude for their services and behave in a way that reflects positively on both SCL/JF and your family at all times.

_____ 10. Your child may be removed from the program at any time (this includes during the application process, before assignment to a provider and after treatment has started) if the child or parent/guardian is **uncooperative** or **disrespectful** to SCL staff or the provider or his/her staff, or fails to comply with any SCL rules and guidelines. During the course of treatment, the provider may, at his/her discretion, refuse to continue treatment and may remove the child's braces. If removed for cause, your child is no longer eligible to reapply to the SCL program.

_____ 11. Broken appliances or loose brackets and bands can cause damage to teeth and the rest of the mouth. Your child must not eat hard or sticky foods or pull on the braces. **If there is frequent damage to the braces, the treatment provider has the option of removing the braces or charging you to repair the damage, which is not covered by this program.**

_____ 12. One (1) 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.**

_____ 13. If your child is accepted into the program, you consent to SCL's use, without charge, of all photos, video or audio recordings of you and your child. SCL may (1) copyright, broadcast, display, publish, re-publish, and reproduce you and your child's image, voice and any statements made by you and him/her, in whole or in part, in any and all media forms; and (2) assign you and your child a fictitious name or use your or his/her first name, likeness, video, photograph, voice, statements and biographic or other information concerning his/her participation with SCL, for fundraising or other promotional and advertising purposes. You and your child agree to participate in surveys and case management during and after treatment.

_____ 14. SCL coordinates all communication between families/children and the treatment providers. Do NOT contact a provider unless instructed by SCL. If you contact a provider without permission, your child may be removed from the program.

Consent and Hold Harmless Agreement

The undersigned has read, understands and agrees to abide by the attached **Program Rules and Guidelines,** which are incorporated herein by reference, for receiving orthodontic treatment through **The Walter S. & Evan C. Jones Foundation** (the "Jones Foundation") as administered by the Virginia Brown Community Orthodontic Partnership d/b/a **Smiles Change Lives** and has been given the opportunity to ask questions about this information. If our application is approved, I consent to allow the Jones Foundation, Smiles Change Lives and their partner doctors to provide orthodontic treatment for my child. I understand that acceptance into the Jones Foundation/Smiles Change Lives program for my child's orthodontic care is based on our (my child's and my) ability to maintain my child's oral 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 oral hygiene and abide by the Program Rules and Guidelines, my child will be removed from the program, his/her braces will be removed and treatment will be terminated with no refund of the $650 Required Financial Investment.** I further agree that if treatment is stopped early 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 the Jones Foundation, Smiles Change Lives and the assigned treatment provider 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 Jones Foundation and Smiles Change Lives do not provide the orthodontic treatment and that all treatment will be provided by an assigned doctor ("partner doctor"). I expressly authorize Smiles Change Lives, the Jones Foundation, the partner doctor and my dentist (as listed on my Dental Referral Form) to share my child's medical records and information with each other in order to coordinate and manage my child's treatment. In consideration of the acceptance of my child's application by Jones Foundation/Smiles Change Lives, we (my child and I) release the Jones Foundation, Smiles Change Lives, the partner doctor and their agents, employees, board members, officers, representatives, and successors and assigns 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 (i) our participation in the Jones Foundation/Smiles Change Lives program, or (ii) any action taken by the Jones Foundation, Smiles Change Lives or the partner doctor based on the Program Rules and Guidelines, including but not limited to my child's removal from the program and the removal of his/her braces. I further acknowledge and understand that the Jones Foundation, Smiles Change Lives and the partner doctor 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 Missouri and is intended to be as broad and inclusive as permitted by the laws thereof or of any other state where Smiles Change Lives program activities occur. Waiver of any provision by Jones Foundation or Smiles Change Lives 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 I have legal authority to make medical decisions for the child, 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 permanent 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 Consent: (Child MUST sign even if under 18 years of age)

Date (mm/dd/yyyy)	Child/Applicant **SIGNATURE** *(Not Parent/Guardian)*	**PRINTED NAME**

DENTAL REFERRAL FORM

APPLICANT: You must provide both of these pages (pgs. 9-10) to your General Dentist and return both pages to SCL upon completion.

☐ Check here to confirm that you have included BOTH pages of the Dental Referral Form in your application packet and that your dentist has completed the REQUIRED sections.

Dear Dental Care Provider:

Your patient is applying to the Jones Foundation and Smiles Change Lives (SCL) with the hopes of receiving braces at a significantly discounted cost. As this child's dental care provider, you play a significant role in the application process by filling out the Dental Referral Form (DRF) below. The DRF helps us determine whether or not a patient is a good candidate for our program. We are screening not only for dental hygiene and orthodontic need but also for applicant motivation. Your participation in this process is critical and makes you an invaluable partner in the Smiles Change Lives program.

Simply fill out the DRF as completely as possible and your patient will include it as a part of their application packet.

- The "General" and "Dental Health" sections **are REQUIRED**; please fill out these sections completely. If these sections are not filled out completely, your patient's application will not be considered.
- The "Functional" section of the DRF is extremely important and helps us gauge the severity of the child's problem. *Please provide your professional opinion on this section.*
- Please staple a business card to the DRF so that we can verify that it was filled out by you or a designated staff member.

If you have any additional comments you would like to provide directly and privately to Smiles Change Lives regarding this child, please e-mail us at info@smileschangelives.org, and be sure to include the child's full name and date of birth. Thank you very much for taking the time to fill out this child's DRF, and starting them on the road to a new smile and renewed confidence.

Sincerely,

The Staff at Smiles Change Lives

DENTIST INFORMATION: *This section is **REQUIRED. Application will not be considered if this section is not fully completed.***

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*

(Continued on next page)

NOTE: Application must be received within 30 days of examination date.

DENTAL REFERRAL FORM pg. 2

Patient Name: _____

DENTAL HEALTH & GENERAL INFO:

***This section is REQUIRED**. Application will NOT be considered if this section is not fully completed.*

CARIES: Does this patient need restorative work at this time? ☐ Yes ☐ No

*(**If "yes", child MUST have restorative work completed before submitting this application.** The application will NOT be considered if the child has cavities.)*

Does this child have good oral hygiene? ☐ Yes ☐ No (Yes or No response ONLY)	How many deciduous (baby) teeth are present? *(If none, write 0)* _____

Impacted teeth: ☐ Yes ☐ No	Physically capable of cleaning teeth: ☐ Yes ☐ No	Missing Teeth: ☐ Yes ☐ No	Have second molars erupted? ☐ Yes ☐ No

Other Functional or Aesthetic Problems/Comments: _____

_____

How long has this child been your patient: ☐ < 1 year ☐ 1-3 years ☐ 3+ years	Do you recommend this child for treatment by an orthodontist? ☐ Yes ☐ No
Does this patient/family have a positive attitude toward dental care: ☐ Yes ☐ No	Does this family/patient keep appointments: ☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely
Does this child have a moderate to severe need for orthodontic treatment? ☐ Yes ☐ No	Is the child AND parent/guardian motivated and interested in orthodontic care? ☐ Yes ☐ No

FUNCTIONAL: *This section is extremely important. Please give your professional opinion.*

Malocclusion:	☐ Class I	☐ Class II	☐ Class III	
Upper Crowding:	☐ None	☐ Mild 0-3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7mm
Lower Crowding:	☐ None	☐ Mild 0-3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7mm
Upper Spacing:	☐ None	☐ Mild 0-3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7mm
Lower Spacing:	☐ None	☐ Mild 0-3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7mm
Overjet:	☐ Normal	☐ Moderate 2-5mm	☐ Severe ≥ 5mm	☐ Underjet
Overbite:	☐ Normal	☐ Moderate (50-75%)	☐ Severe > 75%	☐ Open bite
Crossbite:	☐ None	☐ Anterior	☐ Posterior	
Overall Misalignment:	☐ None	☐ Mild	☐ Moderate	☐ Severe

Date of most recent examination: _____ *Application must be received within 30 days of examination date*

_____ _____ **(Please attach business card for verification)**

Referring Dentist *Signature* (**REQUIRED**) Date Signed

2405 Grand Blvd, Suite 300 | Kansas City, MO 64108 | Phone 888-900-3554