Smile FOR A Lifetime Foundation
THE GIFT OF SMILES

Valeriano Orthodontics
Making Your Smile Shine

# APPLICATION

## PATIENT INFORMATION

Patient's Name: ____________________________________________Age________ Sex: F ( ) M ( )

Birthdate:____/____/____ Social Security #:________________Email:______________________

Home Address:______________________________________________________________________

City, State:____________________________Zipcode:____________How long at this address:____

Home Phone:__________________________School:_____________Grade:____________________

Patients Hobbies:____________________________________________________________________

General Dentist:____________________________Dentist Phone: ____________________________

How did you hear about Smile for a Lifetime? :___________________________________________

## PARENT OR GUARDIAN INFORMATION

Name: ___________________________________Marital Status:_____Email: ___________________

Home Address: _____________________________________________________ Own ( ) Rent ( )

City, State: ____________________________Zipcode:___________How long at this address:_____

Home Phone:__________________Work Phone:____________________Cell:___________________

Social Security #:_________________Birthdate:___/___/___ Relationship to patient:___________

Employer: ____________________________Occupation:____________________________________

Household income (per year): ____________________How many living at this address?:_______

## DENTAL INSURANCE INFORMATION

Do applicants qualify for NC Health Choice or Medicaid? Y or N

Is applicant covered by dental insurance? (specify company and policy):

________________________________________________________________________________

## ADDITIONAL INFORMATION

Application submitted by: ___________________________________Relationship:________________

Email:__________________________________Phone Number:______________________________

## APPLICANT TO ANSWER:

Why do you deserve to be a candidate for Smile for a Lifetime? What is stopping you from getting braces? How do you think braces will change your future?

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Tell us about your family. How many people are in your family? Describe your relationship with them:

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## PLEASE INCLUDE:

*A **recent 5x7 head-shot** photo of applicant with **full smile and teeth showing.**

* 2 letters of reference for applicant (typed and limit each to one page.) These must be written by: School, church, or community leaders that know the applicant.

* 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:

**South Charlotte- Smile for a Lifetime Foundation**
Attn: Sheena Beck and Janie Wilson
7812 Fairview Road
Charlotte, NC 28226
For questions: valerianosmilesforlife@gmail.com

Candidates will be asked to provide verification of family income insuring Smile for a Lifetime that financial requirements are met. All applications, pictures and supporting documents will **NOT** be returned and will become property of Smile for a Lifetime Foundation.