Participant Evaluation Form

Name of Participant: ____
Participant Phone Number: _______________________Email:____________________________

Name of Dentist: ____

Please describe the dental needs addressed: ____
____
____

What was the amount of time between submitting the application and receiving dental care?
Please circle one:

Over 1 year 9 months 6 months 3 months Under 1 month

Comments:
____
____

How far did you travel to see the dentist?
Please circle one:

Over 60 miles 60 miles 30 Miles 15 Miles Under 15 Miles

Comments:
____
____

Tell us about your experience with the dental staff: _____________________________________
____
____

Overall, how satisfied were you with the Smiles program?
Please circle one:

Very Dissatisfied Dissatisfied Neutral Satisfied Very Satisfied

Did the Smiles program meet your expectations? *(please explain)*
____
____
____

What could be improved about the program?
____
____
____

Smiles for Success Foundation
7794 Grow Drive, Pensacola, Florida 32514
Phone (850) 920-474-7292 | Fax (850) 484-8762
info@smilesforsuccess.org | www.smilesforsuccess.org

smiles for success AAWD

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Please write a paragraph for the Success Story page on our website to help other women learn more about the program. Please include how you got involved in the program and how it has affected your life. (Please attach a piece of paper if needed)

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