smiles for success

A Foundation of the
American Association of Women Dentists

Dentist Guidelines

- **Volunteers who are members of the AAWD will be reimbursed up to $1,500 in lab fees per patient. Non-members will be reimbursed up to $1,000 per patient.**

- **Keep dental records as with other patients of record.**

- **Submit In-Kind expense report upon completion of treatment.**
  A copy of the patient's ledger with regular fees that have been written off can be substituted for the In-Kind expense report.

- **Submit Participant Release form and 'Before and After' pictures' to the Central Office upon completion of treatment.**

- **Report any lab-fees that need to be reimbursed by Smiles or that have been donated by a lab.**

- **Report or contact Dental Coordinator with any problems or questions regarding dental treatment and or participants.**

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Agreement for Dental Procedures

Note: **THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S DENTAL RECORD**

Please send a copy to: Smiles for Success Foundation, 216 W. Jackson Blvd., Suite 625, Chicago, IL 60606
Phone (800) 920-2293 • Fax (312) 750-1203 • info@smilesforsuccess.org

1. I hereby authorize Dr. _____ and his/her associates at _____ to perform upon me or the named patient the following procedure(s): _____ _____ in accordance with the provisions set forth below.

2. I understand that the dental services which have been agreed to be provided to me according to this Agreement are limited to those which have been checked off and initialed by Dr. _____ from the following list.

- ☐ Flipper (temporary)
- ☐ Fillings (restorations)
- ☐ Initial cleaning and prophy
- ☐ Initial dental examination
- ☐ X-rays as necessary at discretion of Dentist
- ☐ Root extractions
- ☐ Oral and Dental health education
- ☐ Emergency dental treatment to relieve pain
- ☐ Temporary crowns for teeth nos. _____
- ☐ Extractions
- ☐ Root Canal Therapy
- ☐ Periodontal Therapy and/or Surgery
- ☐ First recall visit at reduced fee
- ☐ Prescription paid by Client
- ☐ Other _____

3. I understand that the Doctor cannot provide any dental services other than those specified in paragraph 2 of this Agreement unless laboratory expenses have been pre-approved by Smiles for Success.

- ☐ Crowns and bridges
- ☐ Orthodontics
- ☐ Partial upper and Partial lower dentures (traditional)
- ☐ Full upper and full lower dentures

4. It is understood and agreed that the services to be rendered by the Doctor are limited, to the above only, and there shall be no obligation to treat said patient's spouse, children, guardian or other family members.

5. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s) that will be performed, as specified in paragraph 2 of this Agreement.

6. I confirm that I have read and fully understand the above and specifically the limitations of the dental services that will be furnished to me pursuant to this Agreement and that all blank spaces have been completed prior to my signing.

Patient:

Signature _____ Print Name _____ Date _____

Witness:

Signature _____ Print Name _____ Date _____

Dentist Certification:
I hereby certify that I have explained the nature, purpose, benefits, risks of, and limitations of the proposed procedure(s). I have offered to answer any questions and have fully answered all such questions. I believe that the patient fully understands what I have explained and answered.

Signature _____ Print Name _____ Date _____