smiles for success

A Foundation of the
American Association of Women Dentists

In-kind Expense Report

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

A copy of the patient's ledger with regular fees that have been written off can be substituted for this form.
Please return this form or the patient ledger to the Smiles for Success Office.

Dentist: _____ Date: _____

Patient Name: _____

Patient Information: Please give information on patient, treated before, new to program, special needs, etc.

_____

_____

_____

Treatment: List all appointments, treatments of patient and estimated expenses

Treatment Explanation	Date of Treatment	Estimated Amount

Doctors and Staff Time: Please list the estimated number of hours each doctor and staff member worked

Doctors and Staff Names	Number of Hours	Estimated Salary

Estimated Treatment In-Kind expenses	
Estimated Salary in-kind expenses	
Total In-Kind Expenses	