



Smile for a Lifetime Foundation of East Contra Costa, California

Application Form

Applicant's Name: _____ D.O.B: _____ Gender _____

Name of Parent or Legal Guardian: _____ Relationship to Applicant: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Name of School: _____ How did you hear about S4L: _____

Name of Dentist: _____ Date of Last Visit: _____

Number of times applicant has previously submitted an application to Smile for a Lifetime: _____

Total Household Income: \$ _____, number of family members _____ (Please include a copy of last year's tax return, W-2s, or a copy of the most recent pay stubs for all family wage earners.)

- 1) Include two 5 x 7 photos of applicant. One photo should be a head shot showing a full smile and the teeth: and one photo should show only the applicant's teeth.
- 2) Include two letters of reference (typed and limited to one page each) from a teacher or community leader that knows the applicant.
- 3) Include a copy of applicant's last report card or school transcript.
- 4) Include complete answers for all the questions on the attached Applicant Questionnaire.

Please mail completed form and all supporting documents to:

Smile for a Lifetime Foundation of East Contra Costa County California
3428 Hillcrest Avenue, #100
Antioch, CA 94531

For questions: 925-757-3356 or S4LFoundation@Sheffieldortho.com

Note: Applications, pictures and supporting documents will not be returned, and will become the property of Smile for a Lifetime of East Contra Costa County, California.

Signature of Parent or Legal Guardian: _____ Date: _____

Applicant Questionnaire

1) Tell us about yourself. What do you like to do? What extracurricular activities do you participate in? Do you do any community service or volunteer work? What are your goals and aspirations?

2) Tell us about your family. How many people live with you, and who are they?

3) Why do you want braces? What prevents you from getting braces now? How do you feel about your smile now? How do you think braces will improve your life now and in the future?

4) Besides bringing the gift of a smile to deserving people another goal of the Foundation is to create a culture of giving within our community. If you are selected to receive this gift what would you do to pay this gift 'forward'?

AUTHORIZATION FOR SMILE FOR A LIFETIME, INC., Robert Sheffield DDS, Inc., TO RELEASE NAME, PHOTOGRAPHS, FILMS AND “PHI” TO MEDIA OUTLETS AND SIMILAR PUBLICATIONS

The undersigned hereby authorizes Smile for a Lifetime, Inc., Robert Sheffield DDS, Inc., Robert Sheffield, DDS to release photograph(s), film, and information regarding the patient’s treatment, including Protected Health Information (“PHI”) pursuant to 45 C.F.R. §164.508(a)(3), for the limited purpose of its newsworthiness to the general public, or for human interest, publicity, marketing and/or advertising, concerning:

Patient’s Name: _____

These records may be used for promotional or publicity purposes and may appear in mass media publications, on the Smile for a Lifetime, Inc. or Robert Sheffield, DDS Inc. internet sites, within other such publications or on similar internet sites, shown in television presentations, and released to media outlets. The patient and/or his/her legal representative agree that the patient’s identification including the patient’s and family’s name may be used in such release(s). This release may be revoked by the patient and/or his/her legal representative at any time, in writing. Such revocation shall only be effective to prevent any expanded future use of the information from the date of revocation of said consent. Otherwise, this release shall continue without expiration. The patient and/or his/her legal representative acknowledge that participation in or treatment under the program, Smile for a Lifetime, is not conditioned upon agreeing to sign this release.

The patient and/or his/her legal representative also acknowledge that PHI and other information, photographs, films, and the like used for the purposes sought by this release could be disclosed by others who view it and that the PHI may no longer be protected by 45 C.F.R. §164.508(a)(3). Finally, the patient and/or his/her legal representative acknowledge that they have been provided a copy of the signed release regarding these disclosures.

I/we understand and acknowledge the forgoing. All questions regarding the requested disclosures have been answered and I/we voluntarily agree to the disclosures outlined above without limitation.

Signed (Patient, or Parent or Legal Guardian if Patient is a Minor)
Address: _____

Phone: _____

Print Name & Date

Witness Signature:

Witness Address:

Witness Phone:

Witness Printed Name & Date