Go the Extra Smile!

APPLICATION FORM

Please print all pages and assure all fields are completed and each item below is included with this application.

[ ] Applicant Questionnaire
[ ] General Dentist Form
[ ] Three 5x7 photos
[ ] Copy of Report Card or Transcript
[ ] Copy of Attendance Record
[ ] Two Letters of Reference

Applicant Information

Applicant's Name: _____ Age: _____ DOB: _____ M / F

School Name: _____ Current GPA: _____ Ave. GPA (past 3 yrs): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Information

Marital Status: *(circle one)* Single Married Separated Divorced Widowed

1. Parent/Guardian Name: _____

Email: _____ Phone: _____

Employer 1: _____ Work Phone: _____

Average Income: _____ # of Family Members: _____

Employer 2: _____ Work Phone: _____

Average Income: _____

2. Parent/Guardian Name: _____

Email: _____ Phone: _____

Employer 1: _____ Work Phone: _____

Average Total Income: _____ # of Family Members: _____

Employer 2: _____ Work Phone: _____

Average Income: _____

Insurance *(circle Yes or No)*

Does the applicant qualify for Denali Kid Care? Yes No

Does the applicant qualify for Medicaid? Yes No

Is the applicant covered by dental/orthodontic insurance? Yes No

Insurance: _____ Policy #: _____

Reference Letters

1. Name _____ Phone: _____

2. Name _____ Phone: _____

How did you hear about Smile for a Lifetime? _____

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APPLICATION FORM (continued)

1) Include three 5x7 photos:
   - a head-shot photo of applicant with full smile and teeth showing,
   - an intraoral shot (inside the mouth) of the upper teeth, and
   - an intraoral shot (inside the mouth) of the lower teeth.

2) Include two letters of reference (typed and limit each to one page) from a school, church or community leader that know applicant.

3) Include handwritten applicant questionnaire completed by applicant.

Please mail completed application form, related documentation, applicant questionnaire, 5x7 photo and reference letters to:

Smile for a Lifetime Foundation
c/o Murray Orthodontics, P.C.
12350 Industry Way, Suite 205
Anchorage, AK 99515
For questions: S4L@murrayorthodontics.com or 907-277-0502 *(ask for Jennifer)*

Candidates chosen for screening may be asked to provide verification of family income which might include a copy of last year's tax return, W-2, or a copy of the most recer insuring Smile for a Lifetime that financial requirements are met. All applicant's photos and supporting documents will **NOT** be returned and will become property of Smile Lifetime Foundation.

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APPLICANT QUESTIONNAIRE (page 1 of 2)

1) I am a deserving applicant for Smile for a Lifetime because:

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

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

4) 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 w your life now and in the future?

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APPLICANT QUESTIONNAIRE (page 2 of 2)

5) Describe your transportation plans to ensure keeping all of your orthodontic appointments.

6) Explain a situation when you followed through on a particular project (briefly state the project, and then in detail discuss or describe all the steps/processes you instituted and/or followed to achieve your desired results)

7) If you had a chance to do a favor for another young person without any expectation of being paid back, what would you do?

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GENERAL DENTIST FORM

This form is to be completed by the applicant's general dentist and/or hygienist

OR

[ ] If you do not have a general dentist please check this box and leave the form blank

Date: _____

Applicant's Name: _____

Applicant's Date of Birth: _____

General Dentist: _____

Office Phone: _____

Date of last dental cleaning & exam: _____

Please list any restorative work that needs to be completed:

_____

_____

_____

_____

Please Check One:

_____ Patient has received a cleaning and is cavity free.

_____ Patient has received all restorative treatment including a cleaning with exam & no additional treatments are necessary.

_____ Patient has received cleaning with exam & restorative treatment has been scheduled.

Scheduled dates the restorative treatment is to be completed:

_____

_____

_____

Signature of Dentist/Hygienist