PO Box 248 * 107 E 10th St
South Pittsburg, TN 37380

Phone: (423) 228-3077

Email: smilesfreedental@yahoo.com

DOCUMENTS NEEDED

TENNCARE patients only – we do not need proof of income. We need a copy of your photo ID, copies of your insurance cards and a completed application. Note: If TennCare is your supplemental insurance along with other dental insurance – we cannot see you.
We see uninsured or TennCare patients only.
We do not take any other kind of insurance.

- We need **copies of income for <u>EVERYONE</u> (unless you have TennCare)** in the household over the age of 18. This determines your poverty level guidelines for the household. If someone over the age of 18 does not have income, they have to fill out our Declaration of Income form.

Types of acceptable proof of income:

- 6 weeks of current pay stubs
- Letter from SSI

(continued on next page)

    - Letter from disability awards
    - Awards letter from SNAP
    - If rental assisted property, copy of lease showing the income your rent is based on.
- **Copy of Photo ID** for the applicant.
- List ALL medications (including non-prescribed medicines) along with the dosage, strength, and reason for taking each medicine.
- List all allergies.
- Copies of insurance cards
- Completed application

APPOINTMENTS ARE MADE ON A FIRST COME, FIRST SERVED A COMPLETED APPLICATION WITH ALL COPIES OF ID'S AND INSURANCE CARDS AND PROOF OF INCOME FOR NON-TENNCARE PATIENTS.

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED OR HELD!

You may turn in the application with copies of all required documents to Smiles on Tuesdays or Thursdays between 10 am – 4 pm or you may mail, email or bring in completed applications. We can make copies if you bring it in to Smiles. Please do not mail any original personal documents.

Smiles is located at 107 East 10th street in the old National Guard Armory behind the Church of God next to Moss Motors.

Thank you for answering all the following questions. It helps us qualify for Grants so we can better serve our patients.

Patient Name:_____ Date of Birth:_____

Smiles, Inc. Application

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Sex (please circle): Male Female Prefer not to say

Height: _____ Weight: _____ SS#: _____

Race (please circle): Black White American Indian/Alaskan Native Asian Multiracial Other

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Home Phone #: _____ Cell Phone #: _____

May we send you text reminders of appointments? (please circle) Yes No

Email: _____ May we send you email reminders of appointments? (please circle) Yes No

Do you have TennCare? Yes No If yes, have you seen another dentist for care? Yes No

If yes - name of Dentist you have been to: _____

Do you have other Dental Insurance? (please circle) Yes No

Name of Insurance:_____

Do you have Medical Insurance? (please circle) Yes No

Name of Insurance:_____

We need copies of all insurance cards.

Drugstore you use: _____ Phone #:_____

In case of emergency, who should we notify? _____

Relationship to patient? _____ Phone #: _____

Secondary Contact: _____

Relationship to patient? _____ Phone #: _____

Do you give us permission to discuss dental or appointment information with above person? Yes No

May we leave dental or appointment information on your answering service? Yes No

Are you unemployed? (please circle) Yes No If yes are you retired or receive disability? Yes No

If unemployed, are you looking for employment? (please circle) Yes No Not applicable

Are you a Veteran? (please circle) Yes No If yes – Thank you for your service!

Are you homeless? (please circle) Yes No

Are you disabled or do you have special needs? (please circle) Yes No

Patient Name:_____ Date of Birth:_____

Health Questionnaire

To give you the best care and treat you safely, we need a complete and honest record of your health.

Do you have or have had any of the following: (please circle y for yes or n for no)

High Blood Pressure Y N

If yes, is it controlled by medication Y N

What does it usually run _____/_____

Excessive bleeding or bruising Y N

History of Blood clots Y N

Stroke Y N

Diabetes Y N

If yes is it controlled Y N

Do you take insulin for it Y N

What does your blood sugar run _____

Joint issues such as:

Artificial Joints Y N

If yes, which joint(s) _____

Arthritis rheumatoid Y N

Other _____

Osteoporosis Y N

Kidney Disease Y N

Liver Disease Y N

High Cholesterol Y N

Thyroid Disease Y N

Epilepsy/ Seizures Y N

Cancer Y N

If yes, what type _____

When treated _____

Pregnant Y N

Heart issues such as:

Heart Attack Y N

Angina Y N

Pacemaker Y N

Shortness of breath upon walking Y N

History of Bacterial endocarditis Y N

Lung Issues such as:

Asthma Y N

COPD Y N

Other _____

Cold Sores Y N

Smoke, use tobacco or vape Y N

Drink alcohol Y N

Use Drugs Y N

Depression Y N

Overly anxious Y N

Panic Attacks Y N

Have any other condition not listed Y N

Please describe _____

_____

_____

How often do you exercise:

None Once a week

Twice a week 3x or more a week

I certify that I have answered the above honestly and to the best of my ability.

Signature:_____ Date:_____

Patient or legal representative

Revised May 3, 2023

Patient Name:_____ Date of Birth:_____

MEDICATION

ALLERGIES:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication you take (include over the counter or not prescribed medication)

Medicine	Dose	Reason for taking

Use additional sheet if needed.

I certify that I have answered the above honestly and to the best of my ability.

Signature:_____ Date:_____

Patient or legal representative

Revised May 3, 2023

Patient Name:_____ Date of Birth:_____

CONSENT FOR EXTRACTION OF TEETH

Please **initial each paragraph after reading. If you have any questions, please ask ***BEFORE*** initialing.

Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery, there are some risks. They include, but are not limited to, the following:

INITIAL EACH LINE

_____1. Swelling and/or bruising and discomfort in the surgery area.

_____2. Stretching of the corners of the mouth resulting in cracking or bruising.

_____3. Possible infection requiring additional treatment.

_____4. Dry Socket- Jaw pain beginning a few days after surgery usually requiring additional care. It is more common from lower extractions, especially wisdom teeth.

_____5. Possible damage to adjacent teeth, especially those with large fillings or crowns (caps).

_____6. Numbness, pain, or altered sensations in the teeth, gums, lip, tongue (including possible loss of taste sensation) and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or damaged. Almost always sensation returns to normal, but in rare cases, the loss may be permanent.

_____7. Trismus- Limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is a result of Jaw Joint Disorder (TMJ), especially when TMJ disease already exists.

_____8. Bleeding- Significant bleeding is not common, but persistent oozing can be expected for several hours

_____9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.

_____10. Incomplete removal of tooth fragments. To avoid injury to vital structures such as nerves or sinus, sometimes small root tips may be left in place.

_____11. Sinus Involvement. The roots of the upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth that may require additional care.

_____12. Jaw Fracture- While quite rare, it is possible in difficult or deeply impacted teeth.

I understand that services may be provided by volunteer dental care providers, and they are not administering care for or in expectation of compensation. I also understand that as volunteer dental care providers, the dentist, facility and all volunteers and any represented agents of Smiles, Inc. are immune from civil liability except for willful misconduct or gross negligence for any act or omission resulting in death, damage, or injury as long as the volunteers acts in good faith and within the scope of his or her duties within the organization providing dental care services.

Signature:_____ Date:_____

Patient or legal representative

Witness signature:_____ (For anyone who assisted in explaining this form)

Revised May 3, 2023

Patient Name:_____ Date of Birth:_____

CONSENT FORMS

Please read and sign for all consents. Treatment will not be provided without all consents signed.

CONSENT FOR TREATMENT

I, the undersigned patient, hereby authorize and consent Smiles, Inc. to the operations, procedures, techniques and clinical photographs that the treating dentist(s) deem necessary for my care. I also hereby consent that any or all operations, procedures and techniques may be rendered by a student(s), resident(s), volunteer(s) or staff dentist of Smiles, Inc.

I understand that prior to any surgical or diagnostic procedure, technique, or taking of any clinical photograph, I will be advised by the treating dentist responsible for my care, and that I may ask questions concerning the treatment. I also understand that post-operative complications may be a normal consequence of the treatment rendered. I further understand that I may revoke this consent before such treatment is provided.

I attest that I have disclosed my health history information, including allergies, reactions to medicine, diseased, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the provider(s) and any other qualified assistants or medical professionals of Smiles, Inc. to perform the procedure(s) needed for my treatment. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures. I authorize any necessary life-saving procedures to be performed in the event of an emergency including a blood transfusion if necessary.

I understand this consent will remain in force until I revoke it in writing. I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue. I have been given the opportunity to ask questions I might have and all questions have been answered in a satisfactory manner.

Patient signature:_____ **Date:**_____

HIPPA and NOTICES of PRIVATE PRACTICES and CONSENT

I hereby consent to the use and disclosure of my protected health information by Smiles, Inc. for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

- Smiles has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternate to the standard method of communication of my protected health information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Smiles, Inc. at the following address: 107 E 10th St, South Pittsburg, TN 37380
- I understand that while Smiles, Inc. may honor these requests, they are not required by law to do so.
- I am aware that Smiles, Inc. reserves the right to change the terms of their Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Smiles, Inc. will make available a revised Notice of Privacy Practice for my review.

Patient signature:_____ **Date:**_____

PHOTO CONSENT

I understand that Smiles, Inc. depends on financial gifts from local business, churches, individuals, and grants to provide affordable dental care to their patients. I understand this is a requirement of the clinic and part of the treatment provided. I give the clinic permission to take my photograph and use for administrative purposes as they see fit.

Patient signature:_____ **Date:**_____

Patient Name:_____ Date of Birth:_____

Smiles, Inc.

Due to the *extreme* need for dental treatment and the number of patients needing treatment, broken appointments **will not be tolerated.**

- It is the responsibility of each patient to cancel appointment if they cannot come to a scheduled appointment.
- You must cancel your appointment forty-eight (48) hours before your appointment.
- If your appointment is not canceled 48 hours in advance it will be considered a broken appointment and you will have to wait **6 months** before another appointment will be made for you.
- If you have 2 broken appointments, you will be dismissed from our program.

I understand and agree to these terms.

Patient Name:_____Date:_____

Signature:_____

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Patient Name:_____ Date of Birth:_____

Financial Information

TENNCARE PATIENTS DO NOT NEED TO FILL OUT THIS PAGE.

Please list everybody in household (including children under the age of 18:

If someone over the age of 18 has no income - fill out the next page - Declaration of Income

NAME	DOB	RELATION	**GROSS** MONTHLY INCOME
		self	

I, the undersigned, certify to the best of my knowledge that the above information is true and I authorize the verification of any and all information for the purpose of determining income eligibility for dental services provided by Smiles, Inc. I understand that I am subject to all applicable Federal and State laws concerning fraud if I knowingly give false or incomplete information to obtain services. I understand I have the right to appeal if my application is denied.

Signature:_____ Date:_____

Patient or legal representative

ATTACH COPIES OF PROOF OF INCOME

Revised May 3, 2023

Declaration of Household Income

Instructions: This form is to be complete by the person applying for assistance if any of the following situations apply to the applicant and/or any household member age 18 and over for the previous month:

Smiles, Inc.

Tenncare patients do not need to fill this page out.

- *Had no income and verification cannot be obtained from a government entity such as the Department of Human Resources, Department of Labor, Public Housing manager, etc.*
- *Received income from occasional work such as lawn care, house cleaning, babysitting, car repair, etc. when a receipt book is not maintained.*
- *Received money from family/friends*
- *Received income not reported elsewhere.*

Applicant's name (please print): _____

Applicant's address (please print): _____

Did you or any household member age 18 and over have **no income** last month? If so, complete the following for every adult:

Name	How long has this person had no income?

Did you or any household member age 18 and over receive income from **occasional work when a receipt book was not maintained,** receive **money from family or friends,** or receive any **income not reported elsewhere** last month? If so, complete the following for you and every adult:

Name	Amount:	Source of Income:

How do you pay your rent/mortgage? _____

How do you pay for food? _____

How do you pay for your utilities? _____

I certify that the information provided above is true and complete to the best of knowledge. I understand I may be required to provide of any information given and that providing false information will invalidate this form and may require the repayment of any assistance received based on the false information. I understand that I am subject to all applicable Federal or State laws concerning fraud.

Applicant's Signature: _____ Date: _____