



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 _____



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Treatment Plan

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

Please submit this form prior to treatment. Only pre-approved lab costs will be reimbursed.

I, _____, understand that the following treatment is being recommended to me by Dr. _____.

Also listed are costs for that treatment and alternative options.

I understand that it will be my responsibility to follow home care instructions given as well as keeping all scheduled appointments. If I fail to call 48 hours in advance to cancel or reschedule my appointment or if I fail to show up for two (2) visits, the privilege of having dental care free of charge or at reduced fees will be revoked immediately.

I also understand that the doctor will provide appropriate dental care to the best of his/her ability, but that there are no guarantees on treatment provided. I hereby release the doctor and the Smiles for Success Foundation from any damages or claims arising from my treatment and I promise not to sue the doctor for any claims arising out of my treatment hereunder.

Smiles for Success reimburses lab bills up to \$1,500 to volunteers who are members of the AAWD, and up to \$1,000 to volunteers who are non-members.

Table with 3 columns: Recommended Treatment, Usual and customary fee, Estimated Lab Fee

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Smiles for Success Board approved Yes [] No [] Date: _____

This agreement is valid for one year from signing date.



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Participant Release Form

In consideration of the service rendered by *Smiles for Success* I hereby grant to *Smiles for Success* the permission to publish and/or copyright any photographs or videos in which I may appear in whole or part. These photographs may be used in advertising, publicity or any other use at the sole discretion of *Smiles for Success*. I hereby waive my right to inspect and/or approve the finished copy or any advertising copy. I, also, hereby grant to *Smiles for Success* the right and permission to publish and/or copyright any written material I have submitted for them.

I hereby release *Smiles for Success*, its successor, affiliates, and all persons acting under its permission or authority from any liability from the use or publication of said photographs, videos or written material I have composed.

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Email: _____

Participants Signature

Date
