



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	



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Laboratory Reimbursement Form

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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. Smiles needs the original invoices mailed or faxed in order to reimburse for lab expenses.

Dr. Name (Provider): _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

Patient Name: _____

Patient referral source: _____

(Name of affiliate agency associated with Smiles for Success)

Laboratory Name: _____

Address: _____

Phone Number: _____

Type of Lab Services:
Description of treatment rendered, include tooth numbers and procedure done

Removable Prosthetics

Denture _____

Partial1 _____

Fixed Prosthetics

Crown _____

Bridge _____

Other _____



Participant Evaluation

(Please attach a piece of paper if needed)

Name of Participant: _____

Name of Dentist: _____

Please describe the dental needs addressed: _____

What was the amount of time between submitting the application and receiving dental care?

Please circle one:

Over 1 year

9 months

6 months

3 months

Under 1 month

Comments:

How far did you travel to see the dentist?

Please circle one:

Over 60 miles

60 miles

30 Miles

15 Miles

Under 15 Miles

Comments:

Tell us about your experience with the dental staff:

Overall, how satisfied were you with the Smiles program?

Please circle one:

Very Dissatisfied

Dissatisfied

Neutral

Satisfied

Very Satisfied

Did the Smiles program meet your expectations? *(please explain)* _____

What could be improved about the program?

Smiles for Success Foundation

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Phone: 800.920.2293 – Fax: 312.750.1203

Email: info@smilesforsuccess.org - Website: www.smilesforsuccess.org

Participant Evaluation *cont.*



Please write a paragraph for the Success Story page on our website to help other women learn more about the program. Please include how you got involved in the program and how it has affected your life.