Smile FOR A Lifetime Foundation
THE GIFT OF SMILES

DAMON ORTHODONTICS

Dr. Paul Damon & Dr. Clay Damon

A Future Full of Smiles, Let It Begin With Us

PATIENT INFORMATION

Patient's name:____Age:___________Sex: F ( ) M ( )
Birthdate:___/___/___Social Security #:________________________Email:_________________________________
Home Address____
City, State:_______________________________________Zip:_____________How long at this address:___________
Home Phone #:________________________________Cell Phone #:____
If patient is a minor, give custodial parent's name or guardian's name:_____________________________________
School:____Grade:____
Patient's Hobbies:____
General Dentist:______________________________________Dentist Phone #:_________________________________
How did you hear about Smile for a Lifetime?____

PARENT OR GUARDIAN INFORMATION

Name:_______________________________________Marital Status:_________
Email:__________________________
Birthdate:___/___/___Social Security #:______________________Relationship to patient:_____________________
Home Address:____Own ( ) Rent ( )
City, State:_______________________________________Zip:_____________How long at this address:___________
Home Phone #:_____________________Cell Phone #:______________________Work Phone #:________________ Employer:________________________Occupation:_____________________Household income (per year)________

Name:_______________________________________Marital Status:_________
Email:__________________________

Birthdate:____/____/____Social Security #:_______________________Relationship to patient:______________________
Home Address:____Own ( ) Rent ( )
City, State:____Zip:______________How long at this address:____________
Home Phone #:______________________Cell Phone #:_______________________Work Phone #:__________________
Employer:__________________________Occupation:______________________Household income (per year)________

ORTHODONTIC INSURANCE INFOMATION

Insured's Name:____________________________________Insurance ID #:_______________________________________
Insured's Birthdate: _____/_____/______ Relationship to patient:____
Insurance Company:___________________________________Phone #:____
Employer:____Group :____
Do you have dual coverage? YES NO If yes, please complete the following section:
Insured's Name:____________________________________Insurance ID #:_______________________________________
Insured's Birthdate: _____/_____/______ Relationship to patient:____
Insurance Company:___________________________________Phone #:____
Employer:____Group #:____

ADDITIONAL INFORMATION

Submitted by:__________________________Relationship:_____________________Email:__________________________
Home Address:__________________________________City:_________________State:_______________Zip:__________
Home Phone #:______________________Cell Phone #:_______________________Work Phone #:__________________

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APPLICANT TO ANSWER

Why do you deserve to be a candidate for Smile for a Lifetime? What is stopping you from getting braces?
How do you think braces would change your future?

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Tell us about yourself. What are your interests and hobbies? What activities are you involved in? What are your goals for the future?

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Tell us about your family. How many people are in your family and describe your relationship with them:

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PLEASE INCLUDE:

- A 5x7 photo of applicant with FULL SMILE AND TEETH SHOWING
- 2 letters of reference including their phone number please be sure it is typed and limited to one page, and reference may not be written by a family member
- Please include a copy of last year’s tax return, W-2 (s), or a copy of the past 12 months pay stubs for ALL family wage earners.

Please mail completed application form with picture, reference letters and verification of income to:

Smile for a Lifetime of Damon Orthodontics

Attn: Jill

12406 E Mission Ave

Spokane, WA 99216

For questions please call Jill (509) 924-9860 or e-mail jill@damon-smiles.com