Smiles of Faith

Beloved, I pray that all may go well with you
and that you may be in good health,
as it goes well with your soul

OFFICE USE ONLY:

Date Received: _____

Appt Date and Time: _____

Appt Location: _____

Appt Info Text Sent: _____

Comprehensive Care Request Form

This application MUST be completed by the patient, unless the patient is a minor (<18 years old).

We are happy to provide dental care to our friends and neighbors who are in need. We are able provide this service to our community due to the hard work of our dental staff and the financial contributions by local foundations, philanthropies, and donors to Smiles of Faith. The care provided is a gift that is made available by the sacrificial giving of others. These resources are limited. It is important to recognize that acceptance into the dental program is not a guarantee. So please take the time to complete the required forms carefully.

****Only completed applications will be processed****

Each form will be reviewed upon receipt and patients will be selected based on patient need, appointment availability, and resource availability. You will be notified to schedule an appointment.

Application Checklist:

☐ Smiles of Faith Patient Application (Page 2 – Completely filled-out with signature and date)

☐ Smiles of Faith Patient Responsibility Contract (Page 3 – Read, Sign and Date)

☐ Acknowledgement of Missed/Cancelled Appointment Policy (Page 4 - Read, Sign and Date)

☐ General Consent and Privacy Policy (Pages 7 & 8 – Read, Sign, and Date)

☐ Return completed Application to Smiles of Faith Staff (By mail, email, or in person)

Smiles of Faith
1301 S Boston Ave
Tulsa, OK 74119

Email: info@SmilesofFaith.org

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Applicant Information:

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Gender:** _____ Age: _____

Home Address:

_____

_____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Race: (Circle) African American / Asian / Caucasian / Hispanic / Native American / Other: _____

Please explain the reason you are requesting assistance from Smiles of Faith:

_____

_____

_____

Dental Needs:

_____

_____

Do you have a current dentist? Yes ☐ No ☐

How long has it been since your last cleaning? _____

Do you have Medicaid / Soonercare? Yes☐ No☐

Do you have other dental insurance or any other means by which to pay for dental care? Yes: ☐ No: ☐

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Signature: _____Date: _____

Patient Responsibility Contract

I. Should Smiles of Faith accept me as a recipient for donated dental services, I agree that it is my responsibility to:

A. Obtain my own transportation and childcare in preparation for dental appointments.

B. Arrive on time or early and not cancel or transfer any dental appointments, unless I have called and received permission from the Smiles of Faith staff.

C. Be courteous and cooperative with the Smiles of Faith staff and volunteer dental office staff.

D. Follow directions of the dentists and staff while in treatment and once treatment is complete to preserve and maintain my dental health, including the practice of regular dental hygiene procedures.

Patient/Guardian Signature: _____

Date: _____

II. In signing this section of the Patient Responsibility Contract, I acknowledge that I do not have dental insurance or any other means of paying for my dental needs.

Patient/Guardian Signature: _____

Date: _____

III. I understand that I can be terminated from the Smiles of Faith program at any time if I have falsified any information on the application for services, or if I do not keep this agreement. Smiles of Faith reserves the right to terminate the contract between a client and Smiles of Faith at their discretion.

Patient/Guardian Signature: _____

Date: _____

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Cancelled and Missed Appointments

Clinic time is the most valuable resource that Smiles of Faith has to offer to the community. It is of the utmost importance that patients are present for appointments to which they have agreed/scheduled.

Missing more than one scheduled appointment will result in dismissal from the dental program.

Appointments may be rescheduled in the case of an emergency **IF** the patient notifies the clinic at least **24 hours** prior to their appointment time.

Cancellations made with less than a 24-hour notice will be considered a missed appointment. This will result in patient dismissal if it occurs more than one time.

Patients must arrive on time for their scheduled appointment**. If the patient arrives more than 15 minutes late, it will be considered a missed appointment.** This will result in dismissal if it occurs more than one time.

Patient/Guardian Signature: _____

Date: _____

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Scope of Care

Smiles of Faith provides free basic dental services. The primary objective of the clinic is to help facilitate a base line of oral health, free from infection and pan. Services provided are outlined below.

Exams

X-rays

Fillings

Simple Extractions

Cleanings

Deep Cleanings

** Patients **MUST** be at least 7 years old to receive care. **

** Sedation and Nitrous (Laughing Gas) are **NOT** available. **

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Adult Health Screening Form

Name: _____ Date of Birth: _____

GENERAL NEEDS:

I would like more information about help with the following: (Please circle all that apply).

- Food
- Housing
- Clothing
- Medications
- No help needed
- Other: _____

SAFETY CONCERNS: (Check all that apply)

- ☐ There is someone in my life who I am afraid of.
- ☐ I feel as though I am in immediate danger.
- ☐ There is someone in my life who is hurting me.

SPIRITUAL NEEDS:

1. Do you consider yourself a part of a religious community? YES NO
2. Would you like to talk with someone about your faith? YES NO
3. Would you like for us to pray with you? YES NO
4. Do you have any other spiritual concerns? _____

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General Consent for Dental Treatment

Please read and sign below. Feel free to ask any questions. Additional consent forms may be required for specific treatments.

Medical History:

I confirm that I have provided an accurate medical history, including allergies, prior reactions, and health conditions.

Exams & X-Rays:

I understand that X-rays are necessary for diagnosis and treatment planning.

Treatment Changes:

I consent to any necessary changes or additional procedures discovered during treatment, following consultation with the dentist.

Medications & Anesthesia:

I understand that prescribed medications, including antibiotics, may cause side effects or allergic reactions. I consent to the recommended anesthesia. I acknowledge that antibiotics can reduce the effectiveness of oral contraceptives.

Oral Hygiene:

I understand the importance of proper home care and routine professional cleanings for maintaining oral health.

Dental Treatment:

I acknowledge that dentistry is not an exact science, and results cannot be guaranteed. Each dentist is solely responsible for the care they provide.

Exposure Incidents:

I understand that, despite precautions, accidental exposure to my blood or body fluids may occur, and I may be asked to consent to testing for the provider's safety.

Patient Information:

Patient Name (Print): _____ DOB: _____

Patient/Guardian Signature: _____ Today's Date: _____

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Smiles of Faith Privacy Policy

Your privacy is important to us. We are committed to protecting your personal and health information.

- **Your Rights**: You have the right to privacy regarding your dental and medical information.
- **How We Use Your Information**: We will only use or share your protected health information (PHI) to provide and coordinate your dental care.
- **No Third-Party Sharing**: We will not share your PHI with any person, company, or entity for any reason other than to continue your treatment, except as required by law.
- **Legal Exceptions**: In certain situations, we may be required to share your PHI without your consent, including:
    - **Public Health and Safety** – Reporting infectious diseases, adverse reactions to medications, or exposure to health hazards.
    - **Legal and Law Enforcement Requests** – Complying with court orders, subpoenas, or mandatory reporting laws (e.g., abuse or neglect cases).
    - **Regulatory and Compliance Audits** – Providing information to government agencies for compliance with healthcare laws.
    - **Emergency Situations** – When disclosure is needed to prevent serious threats to health or safety.
- **Access to Policy**: A copy of this privacy policy is available upon request.

By signing below, you acknowledge that you have been informed of our privacy practices and consent to the use of your information for dental care.

Patient Name (Print): _____

Signature: _____ Today's **Date:** _____