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

Patient Name: _____

Patient DOB: _____

Appt Date/Time/Location:

_____

_____

Comprehensive Dental 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.

Return completed Application to Smiles of Faith Staff

(Applications can be returned by mail, email, or in-person)

Smiles of Faith

1301 S Boston Ave

Tulsa, OK 74119

Email: info@SmilesofFaith.org | Website: www.smilesoffaith.org

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Scope of Care

Smiles of Faith provides free basic dental services to patients who have **NO DENTAL INSURANCE.** The primary objective of the clinic is to help facilitate a base line of oral health, free from infection and pan. Services provided are:

Dental Exams, X-rays, Fillings, Simple Extractions, and Cleanings

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

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

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Applicant Information:

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

Date of Birth (month/day/year): _____ **Gender:** _____

Age: _____

Home Address:

_____

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

Phone: _____ **Email:** _____

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

Please explain your 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: ☐

Signature: _____**Date:** _____

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Patient Health History

Patient Name: _____ Date of Birth: _____

Have you ever had any of the following? Please circle any that apply:

Acid Reflux/GERD	Glaucoma	Radiation
Treatment AIDS or HIV	Growths	Respiratory
Problems Anemia	Hay Fever	Rheumatic Fever
Arthritis	Head Injuries	Rheumatism
Artificial Joints	Heart Disease	Sinus Problems
Asthma	Heart Murmur	Sleep Apnea
Blood Disease	Hepatitis (A B C D E)	Stomach Ulcers
Bisphosphonate Usage	High Blood Pressure	Stroke
Bone Disease	Jaundice	Thyroid Issues
Cancer	Kidney Disease	Tuberculosis
Diabetes	Liver Disease	Venereal Disease
Dizziness or Fainting	Mental Disorders	Excessive Bleeding
Epilepsy	Nervous Disorders	Pacemaker

Current Medications or Attach Medication list:

Medication	Dosage	Condition being treated

Write any additional medications on the back of this paper.

Are you allergic to any medications? YES NO
If yes, please list allergies here: _____
Do you have any medical conditions that require a premedication? YES NO UNSURE
Do you use tobacco products? YES NO
Have you had any complications following dental treatment? YES NO
Do you have a primary care physician? YES NO
Do you have any health problems that need further clarification? YES NO
If yes, please describe here: _____

These answers I have given are true to the best of my knowledge.

Signature of patient or guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

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Patient Responsibility Contract

By signing below, I agree to the following if accepted for donated dental services:

1. **Appointments & Conduct**
    - Arrange my own transportation and childcare in preparation for dental appointments.
    - Arrive on time and not cancel without notifying Smiles of Faith staff.
    - Be courteous and cooperative with staff and volunteers.
    - Follow treatment instructions and maintain good dental hygiene.
2. **Eligibility**
    - I confirm that I do not have dental insurance or other means to pay for dental care.
3. **Termination**
    - I understand that services may be ended if I provide false information or fail to follow this agreement. Smiles of Faith may terminate services at its discretion.

Patient/Guardian Signature: _____ Date: _____

Cancelled and Missed Appointments

Smiles of Faith provides free dental care, and clinic time is our most valuable resource. To ensure we can serve as many people as possible, patients must honor their scheduled appointments.

- **Missed Appointments**: Missing more than one appointment will result in dismissal from the program.
- **Cancellations**: Appointments may be rescheduled only in the case of an emergency, and you must notify the clinic at least 24 hours in advance. Cancellations with less than 24 hours' notice will count as a missed appointment.
- **Late Arrivals**: Patients who arrive more than 15 minutes late will be considered a missed appointment. This will result in dismissal if it occurs more than once.

Patient/Guardian Signature: _____ Date: _____

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General Consent for Dental Treatment

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

By signing below,
• I confirm that I have provided accurate medical history, including allergies and conditions.
• I understand that exams and X-rays are needed for diagnosis and treatment planning.
• I consent to necessary treatment changes or additional procedures after consultation with the dentist.
• I understand that medications and anesthesia may cause side effects or allergic reactions. I also understand that antibiotics can reduce the effectiveness of oral contraceptives.
• I agree to practice proper home care and attend routine professional cleanings.
• I understand dentistry is not an exact science and results cannot be guaranteed. Each dentist is responsible for their own care.
• I understand that accidental exposure to my blood or fluids may occur, and I may be asked to consent to testing for provider safety.

Privacy Policy

We are committed to protecting your personal and health information. A copy of this policy is available upon request.

- **Your Rights:** You have the right to privacy regarding your dental and medical records.
- **Use of Information:** Your protected health information (PHI) will only be used or shared as needed for your dental care.
- **No Sharing:** We do not share PHI with others except as required by law.
- **Exceptions:** Disclosure without consent may occur for:
    - Public health and safety reports
    - Court orders or mandatory reporting (e.g., abuse)
    - Government compliance audits
    - Emergencies to prevent serious harm

By signing, you acknowledge these practices and consent to the use of your information for dental care.

Patient Name (Print): _____ DOB: _____

Signature: _____ Date: _____

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Adult Health Screening Form (Optional)

Name: _____ **Date of Birth:** _____

1. General Needs

Please check all that apply (ask for our community resource list if needed):

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

2. Safety Concerns

- ☐ 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.
- ☐ I do not have safety concerns.

3. Spiritual Needs

Do you consider yourself part of a faith or religious community? ☐ Yes ☐ No

Would you like to talk with someone about your faith? ☐ Yes ☐ No

Do you have any spiritual concerns that we can help with? ☐ Yes ☐ No

List them here: _____