Doctor Request Form

Today's Date:

Doctor Name:

Doctor Address:

Doctor Email Address:

Contact Name at Practice:

Contact Name Email Address:

Patient Name:

Patient Email Address:

Requested Support by Doctor: U OR L or Both (Circle)

Awarded Support by HSF: U/L (Circle) What do you typically charge per arch:

Patient Dental Health History:

Why you feel this patient is a HSF candidate:

Justification: Doctor hereby agrees and acknowledges that their time is donated and not billed to the patient receiving this in-kind product from Hybridge. Implants not included.

Declaration: Hybridge Smile Foundation committee has reviewed the submission received by the above applicant. After careful review of the request, we find that awarding the requested donation will aid in the overall health of the patient above named. This support will allow the doctor/practice to help a patient improve their oral health when they could not afford to do so on their own. This good deed aligns with our mission to transform people's lives.

Our decision has been made independent of and without consideration of sales, if any, associated with the applicant.

Doctor/Practice Signature

X

Date Signed

Hybridge Smile Foundation Executive Signature

X

Date Signed