



Smile for a Lifetime of Central Texas

Application Form

Applicant's Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Gender \_\_\_\_\_

Name of Parent or Legal Guardian: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Name of School: \_\_\_\_\_ How did you hear about S4L: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Number of times applicant has previously submitted an application to Smile for a Lifetime: \_\_\_\_\_

Total Household Income: \$ \_\_\_\_\_, number of family members \_\_\_\_\_ (Please include a copy of last year's tax return, W-2s, or a copy of the most recent pay stubs for all family wage earners.)

Is the applicant of special needs or require special medical care: Yes  No

If yes, please provide additional information: \_\_\_\_\_

- 1) Include two 5 x 7 photos of applicant. One photo should be a head shot showing a full smile and the teeth: and one photo should show only the applicant's teeth.
2) Include two letters of reference (typed and limited to one page each) from a teacher or community leader that knows the applicant.
3) Include a copy of applicant's last report card or school transcript.
4) Include complete answers for all the questions on the attached Applicant Questionnaire.

Questionnaire must be completed by applicant only. Applications submitted that are completed by someone other than the applicant will be disqualified.

Please mail completed form and all supporting documents to:

Smile for a Lifetime of Central Texas
3106 South WS Young Drive Suite A-101
Killeen, Texas 76542

Signature of Parent or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Note: Applicants, pictures and supporting documents will not be returned, and will become the property of Smile for a Lifetime of Central Texas.



### Applicant Questionnaire

1) Tell us about yourself. What do you like to do? What extracurricular activities do you participate in? Do you do any community service or volunteer work? What are your goals and aspirations?

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2) Tell us about your family. How many people live with you, and who are they?

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3) Why do you want braces? What prevents you from getting braces now? How do you feel about your smile now? How do you think braces will improve your life now and in the future?

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4) Would you be willing to continue will dental care and visits if needed?

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5) If you had a chance to do a favor for another young person (or ideally three other young people), without any expectation of being paid back, what would you do?

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**\*The Board of Directors may elect to conduct a panel interview prior to selection of candidates.**

**AUTHORIZATION FOR SMILE FOR A LIFETIME, INC.,  
CENTRAL TEXAS ORTHODONTICS, TO RELEASE NAME, PHOTOGRAPHS,  
FILMS AND "PHI" TO MEDIA OUTLETS AND SIMILAR PUBLICATIONS**

The undersigned hereby authorizes Smile for a Lifetime, Inc., Central Texas Orthodontics, Dr. Scott V. Law, D.M.D, to release photograph(s), film, and information regarding the patient's treatment, including Protected Health Information ("PHI") pursuant to 45 C.F.R. §164.508(a)(3), for the limited purpose of its newsworthiness to the general public, or for human interest, publicity, marketing and/or advertising, concerning:

Patient's Name: \_\_\_\_\_

These records may be used for promotional or publicity purposes and may appear in mass media publications, on the Smile for a Lifetime, Inc. or Central Texas Orthodontics internet sites, within other such publications or on similar internet sites, shown in television presentations, and released to media outlets. The patient and/or his/her legal representative agree that the patient's identification including the patient's and family's name may be used in such release(s). This release may be revoked by the patient and/or his/her legal representative at any time, in writing. Such revocation shall only be effective to prevent any expanded future use of the information from the date of revocation of said consent. Otherwise, this release shall continue without expiration. The patient and/or his/her legal representative acknowledge that participation in or treatment under the program, Smile for a Lifetime, is not conditioned upon agreeing to sign this release. The patient and/or his/her legal representative also acknowledge that PHI and other information, photographs, films, and the like used for the purposes sought by this release could be disclosed by others who view it and that the PHI may no longer be protected by 45 C.F.R. §164.508(a)(3). Finally, the patient and/or his/her legal representative acknowledge that they have been provided a copy of the signed release regarding these disclosures.

I/we understand and acknowledge the foregoing. All questions regarding the requested disclosures have been answered and I/we voluntarily agree to the disclosures outlined above without limitation.

Signed (Patient, or Parent or Legal Guardian if Patient is a Minor)

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Witness \_\_\_\_\_