SMILE
SCHOLARSHIP

APPLICATION CHECKLIST

☐ Application completed as directed

☐ Contract read and signed by guardian and applicant

☐ Application questionnaire, completed by applicant

☐ Household information

☐ Dental referral

☐ Screening (will be scheduled by our office after the application is received)

ABOUT & QUALIFICATIONS

This scholarship program is for children ages 11-17 who reside in Windham and Cheshire Counties who meet financial and orthodontic needs. The scholarship is created by Dr. Miller, owner of Keene/Brattleboro/Rindge Orthodontic Specialists.

All applicants will be reviewed by a board of directors and six scholarships will be awarded each year to applicants meeting the qualifications.

- Must reside in Windham or Cheshire County
- Must be between the ages of 11 and 17
- Must be enrolled in school
- Must have good dental hygiene
- Must follow and abide by treatment plan set by Dr. Miller
- Must meet financial requirements
- Must have a need for braces
- Must not have already started treatment

Questions? Contact Marketing@KeeneOrtho.com

APPLICATION

Today's Date:_____ **Primary Dentist**:_____

Applicant's Last Name:_____**First Name:**_____**Middle:**_____

Applicant's Date of Birth (MM/DD/YYYY):_____**Applicant's Age:**_____

Applicant's Gender: M/F

School Currently Enrolled in:_____ **Address**:_____

Current Grade:_____

If You are Over the Age of 16, what are your plans in the next 3 years? _____

_____

Home Address:_____**City**_____**State**_____**zip**_____

Home Phone:_____**Cell Phone:**_____

Email:_____

There are many reasons people get braces, please select the following that apply to you:

- ☐ Discomfort while eating/drinking
- ☐ Speech impediment
- ☐ It is hard to clean my teeth
- ☐ Jaw/mouth pain
- ☐ I am embarrassed to smile
- ☐ I look down when talking
- ☐ I cover my mouth when I laugh
- ☐ I get teased about my teeth

Guardian Name: _____**Occupation:**_____
Employer:_____

Guardian Name: _____**Occupation:**_____
Employer:_____

Have any other people in your household been treated by Dr. Miller? If yes, whom?_____

_____

Why would you like your child to be awarded this scholarship?_____

_____

_____

_____

_____

_____

_____

_____

Best Number and Email to Reach You At?
Phone:_____ **Email:**_____

APPLICATION QUESTIONNAIRE

(handwritten and completed by applicant)

1. **Tell us about yourself. What do you like to do? Favorite hobbies, extracurricular activities, and the types of goals and aspirations in life. etc.**

2. **Please tell us, in detail, why you would like braces and/or orthodontic treatment and how will orthodontia change your life? Etc**

3. **What makes you smile?**

SCHOLARSHIP CONTRACT

If chosen for a scholarship by the screening committee to receive orthodontic treatment by Dr. Miller there are a few guidelines required for treatment.

By submitting and signing this application you understand and agree to the following:

1. I agree that appointments will be at the discretion of Dr. Miller and his team.
2. I understand that this can mean scheduling appointments during non-peak hours.
3. I acknowledge that appointments must be kept in order to achieve an expeditious and desirable result.
4. I also understand that keeping appointments is essential to treatment success and it is a requirement of accepting care from Dr. Miller.
5. If you must reschedule appointments, give the practice 24 hours' notice. If more than two appointments are missed or appointments are constantly rescheduled it will be considered out of compliance, which is grounds for removal of braces and revocation of the scholarship.
6. If you must relocate prior to the conclusion of treatment, Dr. Miller will do his best to find another service provider. However, it is not guaranteed that treatment will be given at no cost from a new provider.
7. One retainer will be provided as part of the scholarship, any replacements will not be covered by the scholarship and will have to be paid for out of pocket if lost or broken.

Direct responsibilities of the patient:

1. Maintain excellent oral hygiene (tooth brushing and flossing) If unwilling to meet expectations due to medical and dental health risks, treatment will be discontinued.
2. Follow the rules for eating habits. This will greatly reduce breakage of appliances (ie/braces) and is necessary for satisfactory completion of treatment.
3. Cooperate. More than two (2) loose brackets may be deemed sufficient evidence that cooperations is not sufficient to meet minimal requirements for treatments.
4. Other cooperation issues are with failure to cooperate with maintenance of auxiliaries including elastics, etc
5. Attitude. You are expected to maintain an exceptionally appreciative and respectful attitude once accepted into orthodontic treatment or any other aspect of treatment supported by Dr. Miller and his team. Rude behavior is unacceptable.
6. **ATTENTION:** Failure to fulfill your responsibilities may result in removal of orthodontic equipment and discontinuation of treatment **Applicant Initials**:_____
7. **ATTENTION:** Honesty is expected. Any misrepresentation, falsification or exclusion of income will be grounds for dismissal from the program. Future application will not be considered. There are many deserving children who are in need of orthodontics, we are here to serve those in greatest need.
   Guardian Initials:_____

   Media Disclaimer: If your child is the chosen applicant, you consent to use, without charge, of all photos, video and audio recordings of your child.
   Legal Guardian Consent: I certify that I am the legal guardian of the child listed on this application. I have all rights and authority to make medical decisions for the child, that all information in this application is true and correct.

This scholarship is intended specifically for underserved and deserving children in the community. There are many children who need and deserve an award winning smile and while we do our best to serve those greatest in need, it is a competitive process and not everyone will receive a scholarship. Please take your time on your application; your time and effort will be taken into consideration when selecting applicants for scholarships.

_____	_____	_____
Applicant's Name Printed	***Applicant, Signature***	***Date***
_____	_____	_____
Guardian's Name Printed	***Guardian's Signature***	***Date***

DENTAL REFERRAL FORM

Dear Dental Care Provider,

One of your patients is applying for a braces scholarship at our office. As their dental care provider, it is very important we receive feedback from you regarding the patient to determine if they will be a good candidate. Please complete the form below and return it to our office.

To Be Completed by applicant's dentist.

Patient Name (Last, First):_____

Dentist's Name: _____

Dentist's Address:_____

Dentist's Contact Info:

Phone:_____ **Email:**_____

Does the patient need restorative work at this time? Please circle one ***Yes*** ***No***
Does the patient have good oral hygiene? ***Yes*** ***No***
Impacted Teeth: ***Yes*** ***No***
Other Functional or Aesthetic Issues/Additional Comments:_____
_____

How long have you been treating the patient:_____
Does the patient keep appointments: (please circle one)

Never ***Rarely*** ***Sometimes*** ***Mostly*** ***Always***

_____

Dentist's Signature ***Date***

KEENE BRATTLEBORO RINDGE
ORTHODONTIC SPECIALISTS
LANCE R. MILLER, DDS, MS

HOUSEHOLD INFORMATION

How many people live in your household?		*Number of Adults*	
Is anyone in the household employed? *If Yes, please list below*	*Yes* *No*	*Number of Children*	

PRIMARY SOURCES OF INCOME

Name:	*Name:*
Employer Name:	*Employer Name:*
Hourly wage/salary:	*Hourly wage/salary:*
Hours worked per week:	*Hours worked per week:*
Gross Income per month:	*Gross Income per month:*

OTHER SOURCES OF INCOME

Lump Sum Payment (Lawsuit, settlement, social security, SSI, SSDI, Inheritance, lottery, other	*Yes*	*No*	*Amount:*	*Frequency:*
Child Support or Alimony (please circle)	*Yes*	*No*	*Amount:*	*Frequency:*
Unemployment:	*Yes*	*No*	*Amount:*	*Frequency:*

EXPENSES

Please do not include living expenses , ie car insurance, utilities

Do you pay for Adult daycare, child support, alimony, child daycare or medical expenses? YES? NO? If Yes, please list below

TYPE OF EXPENSE	*WHO IS IT FOR*	*FREQUENCY*	*AMOUNT*
Rent/Mortgage			