PATIENT APPLICATION

TO BE CONSIDERED FOR THE DONATED ORTHODONTIC SERVICES PROGRAM, COMPLETE THE FOLLOWING:

- [ ] **DOS PATIENT APPLICATION**

  COMPLETE THE ENCLOSED APPLICATION WITH ALL REQUIRED ATTACHMENTS.

- [ ] **PARENTS OR GUARDIANS WILL NEED TO PROVIDE PROOF OF INCOME (FEDERAL TAX FORM 1040/1040EZ OR SSI AWARDS LETTER). THE CHILD APPLYING FOR SERVICES MUST BE LISTED AS A DEPENDENT.**

  PLEASE INCLUDE A COPY OF PROOF OF INCOME WITH YOUR APPLICATION OR FAX. BE SURE TO INCLUDE YOUR CHILD'S NAME IF FAXED.

- [ ] **PATIENT QUESTIONNAIRE**

  HAVE YOUR CHILD COMPLETE THE "ABOUT YOUR CHILD" QUESTIONNAIRE (SEE LAST PAGE OF THIS PACKET) AND INCLUDE THE COMPLETED FORM WITH YOUR CHILD'S APPLICATION.

- [ ] **DENTIST REFERRAL FORM**

  HAVE YOUR CHILD'S GENERAL DENTIST COMPLETE THE ENCLOSED DENTIST REFERRAL FORM. YOUR DENTIST'S OFFICE CAN RETURN THE FORM BY FAX.

MAIL APPLICATION TO:
AAO-DONATED ORTHODONTIC SERVICES PROGRAM
401 N. LINDBERGH BLVD.
ST. LOUIS, MO 63141

FAX: 314-689-0293

DUE TO HIGH DEMAND, APPLICATIONS WILL BE REVIEWED QUARTERLY. STATUS UPDATES WILL BE SENT OUT TO FAMILIES AS THE APPLICATIONS ARE PROCESSED.

QUESTIONS? 800-424-2841 X582

Patient Application

American Association of Orthodontists

DOS Donated Orthodontic Services

Online Form Available: https://www.aaoinfo.org/_/donated-orthodontic-services/
Mail: AAO, Attn: Donated Orthodontic Services
401 North Lindbergh Blvd., St. Louis, MO 63141
Fax: Attn: Donated Orthodontic Services @ 314.689.0293
Questions: 1.800.424.2841 x582

Today's Date:

Child's Name: **DOB:**

Child's Address:

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

Child's Gender: ☐ Male ☐ Female ☐ Other_____

Child's Race and Ethnicity: *Select all that apply. Information collected will only be reported on a program scale and not connected to the individual recipient.*

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander
☐ White or Caucasian
☐ Multi-Racial/Multi-Ethnic
☐ Other_____

Does your child have a dentist and/or has been seen recently in a dental clinic?
Please note your child will need to be seen by a dentist before acceptance into the DOS program. A dentist referral form is required.
☐ Yes ☐ No

Dentist's Contact Information
Your child's dentist or dental clinic will need to complete a DOS referral form (last page of this document)

Dentist Name:_____ Phone Number:_____

Does your child have Medicaid benefits? ☐ Yes ☐ No

Does your child have dental insurance? ☐ Yes ☐ No

Has your child been evaluated by an Orthodontist? ☐ Yes ☐ No

If yes, which Orthodontist did they see?

Briefly describe your child's dental needs:

Where does your child reside? *By completing this form you represent that you have legal rights to make medical decisions for the child.*
☐ Child lives with one or both parents
☐ Child lives with a guardian/family member
☐ Child lives with a foster family/custody of the state (skip to page 3)

Parent/Guardian Information

Parent/Guardian #1	**Relationship to Child:**
First Name:	**Last Name:**
Phone Number:	**Cell Phone Number:**
Email Address:	
Parent/Guardian #2	**Relationship to Child:**
First Name:	**Last Name:**
Phone Number:	**Cell Phone Number:**
Email Address:	

Please list any adults that can receive information regarding your child.
List any relative, step-parents, etc. that can obtain information regarding the child and their DOS treatment.

Name	Phone	Email	Relationship

Financial Information

Household Members: *List everyone living in the child's home (including parents and child requesting treatment). If more room is needed, attach another sheet.*

Name	Age	Relationship

Sources of Household Income
Please include monthly household income. If the category does not apply, just leave it blank. If you need additional space, feel free to attach another page.

Household Member Name (First, Last)	Monthly Wages	Social Security (SSI)	Disability (SSDI)	Child Support	Unemployment	Temporary Assistance (TANF)	Other
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$

Parent or guardians must attach a copy of the most recent year's federal tax return (1040/1040EZ) or Social Security (SSI) awards letter with this application for review. Your child must be listed as a dependent in your household.

Foster Care/State Custody Information

Contact Information	**Relationship to Child:**
First Name:	**Last Name:**
Phone Number:	**Cell Phone Number:**
Email Address:	

Do you have legal documentation that allows you to make medical decisions for this child? ☐ Yes ☐ No
Please attach a copy of the documentation.

Please list any adults that can receive information regarding this child.
List any relatives, case managers, social workers, etc. that can obtain information regarding the child and their DOS treatment.

Name	Phone	Email	Relationship

Program Information

How did you hear about the DOS Program?

How far will you travel for orthodontic treatment?
We will do our best to match you with a DOS provider close to your child's home.

☐ Less than 10 miles from the child's home
☐ 11-19 miles from the child's home
☐ 20-25 miles from the child's home
☐ More than 20 miles from the child's home
☐ Other:_____

Does your child have any special needs or medical concerns? If so, please explain.

Additional Information (share anything else you would like us to know)

DOS Program Guidelines

Please read the following statements.
If you understand and agree to the conditions, please mark the "I agree" checkbox.

I understand that I will need to provide personal information that includes but is not limited to medical, dental, and financial condition.

I give my consent for the program coordinator to obtain information from my child's physician, dentist, contact people I listed, and/or government or private agencies in order to determine eligibility for the DOS program.

I understand information provided by me or others as noted above may be given only to the volunteers involved in my child's treatment and will be held confidential.

I give permission for the program coordinator to share information about my child with one or more volunteer Orthodontists in the DOS program.

I realize that the application to the DOS program does not assure my child will be referred for an examination or that he or she will be accepted as a patient following an examination.

I understand that the American Association of Orthodontists (AAO), which coordinates the DOS program, will determine whether my child is eligible for the program and, if so, will seek to refer my child to a participating volunteer orthodontist. I further understand that the orthodontist, not the AAO, is solely responsible for diagnosis and any possible dental treatment that my child might receive.

I understand that the orthodontist has volunteered to treat my child's existing dental condition only and is not obligated to provide donated care in the future or to maintain my child as a patient.

I understand the importance of keeping all scheduled appointments. Failure to do so, without at least 24 hour notice to the orthodontists, can disqualify my child from obtaining further treatment through the program.

I agree that I will authorize the treating orthodontist to release necessary information regarding my child's patient status to the AAO DOS Program Coordinator throughout treatment.

To the best of my knowledge, the information provided on this form is a full and accurate disclosure of my current physical, medical, and financial status.

☐ I agree

Parent/Guardian Name *(Please Print)*
Patient Name & Signature required if 18 years old.

Parent/Guardian Signature

Foster Parent/State Custody Name *(Please Print)*

Foster Parent/State Custody Signature

Please read the following DOS Program Rules with your child.
If you both understand and agree to the conditions, please sign below.

1. Donated Orthodontic Services (DOS) provides for orthodontic treatment only. Extractions, dental cleanings, oral surgery, periodontal therapy, and any other treatment that may be necessary before, during, or after orthodontic treatment are the financial responsibility of the patient's parents or legal guardians.

2. If your child has cavities or periodontal disease (gum disease), these conditions must be completely remedied before orthodontic treatment begins.

3. Your child must have a general dentist, who must verify that all necessary dental treatment has been completed before orthodontic treatment begins. In addition, your child must maintain regular dental appointments and cleanings during orthodontic treatment.

4. During treatment, if your child does not brush and floss properly, cavities can form around the braces. If your child does not maintain proper oral hygiene or if cavities form which are not remedied, the treating orthodontist has the option to remove the braces and end the orthodontic treatment. Your child may be dismissed from the DOS Program.

5. If your child is accepted into the DOS Program, orthodontic treatment will be provided by the assigned orthodontist only. If you move away from the treating orthodontist, the DOS Coordinator will attempt to find your child another treating orthodontist; however, DOS cannot guarantee that this will be possible. If you move before the orthodontic treatment finishes and DOS is unable to find a new orthodontist, you must advise your treating orthodontist and make any arrangements necessary to complete treatment, including finding a new orthodontist, which will become your financial responsibility, or having the current orthodontist remove the braces.

6. Regular orthodontic appointments are necessary to make sure the teeth move as expected and no unwanted movement occurs. Most of these appointments will be during school hours. It is your responsibility to make sure that all of the scheduled appointments are kept. Failure to maintain regularly scheduled appointments on a continued basis is grounds for the treating orthodontist to remove the braces and end the orthodontic treatment.

7. You and your child must completely follow the treatment plan recommended by your orthodontist. If you fail to follow the treatment plan, the treating orthodontist has the option to refuse to continue treatment, to remove the braces, and to end the orthodontic treatment.

8. During orthodontic treatment, your child must cooperate with the assigned orthodontist. Failure to cooperate fully with the orthodontist or to maintain proper behavior so that the treatment can be delivered can result in the orthodontist refusing to continue orthodontic treatment until the improper behavior is corrected or removing the braces and ending treatment.

9. Broken appliances or loose brackets and bands can cause damage to the teeth and the rest of the mouth. Your child must take special care not to eat hard or sticky foods or pull on the braces. If there is frequent damage to the braces, the treating orthodontist has the option of removing the braces or charging you to repair the damage, which is not covered by the DOS Program.

10. One retainer, which is necessary to keep the teeth from shifting, will be provided as part of orthodontic treatment at no charge. If the retainer is damaged or lost, you will be charged for a replacement retainer.

Adult's Name *(Please Print)*	Adult's Signature	Date
Child's (Patient's) Name *(Please Print)*	Child's (Patient's) Signature	Date

Dentist Referral Form

American Association of Orthodontists

DOS Donated Orthodontic Services

Referring Dentist: Your patient has applied to received Donated Orthodontic Services. Please complete the referral form on their behalf.

Mail: AAO, Attn: Donated Orthodontic Services
401 North Lindbergh Blvd., St. Louis, MO 63141
Fax: Attn: Donated Orthodontic Services @ 314.689.0293
Questions: 1.800.424.2841 x582

Today's Date:

Patient Name: **DOB:**

Date of last appointment: _____

How often is the patient seen in your office? _____

Does the patient's family keep appointments?	☐ Yes	☐ No
Is the patient in need of orthodontic treatment?	☐ Yes	☐ No
Is the child motivated to receive orthodontic treatment?	☐ Yes	☐ No

Description of Patient's Current Condition:				
Malocclusion	☐ Class I	☐ Class II	☐ Class III	
Spacing	☐ Mild ≤ 3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7 mm	
Crowding	☐ Mild ≤ 3 mm	☐ Moderate 4-6 mm	☐ Severe ≥ 7 mm	
Overjet	☐ Normal	☐ Moderate 2-5mm	☐ Severe ≥ 6mm	
Crossbite	☐ None	☐ Anterior	☐ Posterior	
Overbite	☐ Normal	☐ Moderate (50-75%)	☐ Severe > 75%	☐ Open Bite
Misalignment	☐ None	☐ Mild	☐ Moderate	☐ Severe
Description of Dentition:		☐ Primary	☐ Mixed	☐ Permanent
Is the patient carries free?		☐ Yes ☐ No		
Does the Patient have good oral hygiene?		☐ Yes ☐ No		

Comments:

Dentist Name *(Please Print)*

Dentist Signature

Dentist Phone Number

Thank you for your assistance!

American Association of Orthodontists

DOS Donated Orthodontic Services

ABOUT YOUR CHILD

DOS APPLICATION QUESTIONNAIRE

PARENTS/GUARDIANS: PLEASE HAVE YOUR CHILD COMPLETE THE QUESTIONS BELOW. FOR MORE SPACE, FEEL FREE TO ATTACH ADDITIONAL PAGES.

CHILD'S NAME:

WHAT IS THE BEST PART ABOUT BEING YOUR AGE?

WHAT DO YOU WANT TO BE WHEN YOU GROW UP?

IF YOU COULD HAVE ANY SUPERPOWER, WHAT WOULD IT BE AND WHY?

YOUR FAVORITE THINGS

FOOD:

SONG:

COLOR:

HOBBY:

WHAT DO YOU LOVE MOST ABOUT YOURSELF?

TELL US ABOUT **YOU** IN **ONE** WORD:

ONE FUN FACT ABOUT YOU:

WHAT WOULD HAVING BRACES MEAN TO YOU? HOW WOULD THEY MAKE YOUR LIFE BETTER?