



Smile for a Lifetime Application Form

Please check the box indicating each additional piece of information is included:

- General Dentist Form Two Letters of Reference Copy of Report Card or Transcrip
- Headshot Applicant Questionnaire

Applicant Information

Applicant's Name: _____ Age: _____ DOB: _____ M/F

School Name: _____ Current Grade Average: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Email: _____ Phone: _____

Name of Dentist: _____ Date of Last Visit: _____

Is the applicant of special needs or require special medical care? (Circle One) Yes No

If yes, please provide additional information: _____

Has the applicant received prior orthodontic services? (Circle One) Yes No

If yes, please name the Dr who gave care and what services: _____

of times applicant applied to Smile for a Lifetime: _____

Parent/Guardian Information

1. Parent/Guardian Name: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Email: _____ Phone: _____

Employer: _____ Work Phone: _____

Average Income: _____ # of Family Members: _____

2. Parent/Guardian Name: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Email: _____ Phone: _____

Employer: _____ Work Phone: _____

Average Income: _____ # of Family Members: _____

Insurance:

Is the applicant covered by dental insurance? Yes No

Insurance: _____ Policy #: _____

References:

1. Name _____ Phone: _____

1. Name _____ Phone: _____

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