We will be unable to see your child unless BOTH SIDES of the form are completed and all 3 signature lines are SIGNED
PORTABLE DENTAL PROGRAM – INCOME GUIDELINES TO RECEIVE SERVICES
200% of Federal Poverty Level guidelines
You MUST provide your household income to be eligible for free dental care from Miles of Smiles, Inc.

<table>
<thead>
<tr>
<th>Names of ALL household members</th>
<th>Gross Monthly Earnings (before deductions)</th>
<th>Monthly welfare, child support and alimony</th>
<th>Monthly payments from pensions, retirement, Social Security</th>
<th>Any other monthly income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3.</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4.</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5.</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Signature of Adult Household Member ______________________ Date

I give my informed consent for the dentists and their auxiliary staff to take x-rays and photos of my child’s mouth, face and teeth to provide the care the dentist deems necessary for the treatment of his/her oral condition. I will receive information advising me of my child’s oral health needs. I also authorize the release of information for any applicable insurance coverage.

Please check any procedure you would NOT like completed in our program:

- Exam
- Cleaning
- X-Rays
- Sealants
- Fillings
- Fluoride Application
- Stainless Steel Crowns
- Pulpotomy
- Extractions
- Space Maintainers
- Nitrous Oxide / Laughing Gas (Not used in schools, Office Use Only)

Signature of Parent / Legal Guardian ______________________ Date

I certify that all of the above information is true and correct and current. I understand that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal Laws.

I, ________________________________, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature Parent / Legal Guardian ______________________ Date

PHOTO RELEASE (Do not sign if you wish to decline)

I authorize Miles of Smiles, Inc. to take photographs my child’s teeth, jaws, and face. I understand that the photographs will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc). I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Signature Parent / Legal Guardian ______________________ Date