Through Jerene's Wish

To qualify for Jerene's Wish:

- Applicants must have good oral hygiene, currently not wearing braces, and must be motivated to receive orthodontic care.

- Applicants must complete the application and have their dentist complete a dental referral form.

- Applicants complete a one-page essay referencing why you would like to be selected for the ***Jerene's Wish*** Program.

- The applicant or parent/guardian meets the maximum income guidelines of:

A family of two	$20,000
A family of three	$25,000
A family of four	$30,000
A family of five	$35,000
A family of six	$40,000
A family of seven	$45,000
A family of eight	$50,000

  - Based on most recent federal tax form (1040, not W-2)
  - For children of divorced parents- If you share joint custody or alternate claiming your child please include both parents' tax returns.
  - Net Taxable Income will be used for farm families and self-employed persons.
  - Limit 2 patients per family.

- The applicant and parent/guardian must agree to follow **all** Program Rules and Regulations as stated on pages 6 and 7.
- *The* ***Jerene's Wish*** program allows treatment to be provided at an 80+% discount to eligible applicants. Because of this significant discount the ***Jerene's Wish*** orthodontic fee of $1500 must be **paid in full prior to treatment start**.

How the application process works:

1. After receiving a completed application with all required documents, the ***Jerene's Wish*** Advisory Board will review it to determine if the applicant qualifies for the program.

2. If the applicant qualifies for the ***Jerene's Wish*** program the applicant will be added to the orthodontic screening list. Depending on program demand and capacity, it could take up to 6 months to receive this screening. There is no charge for the screening appointment.

3. Applicants will be notified approximately 4 weeks prior to the screening appointment date and time.

4. Applicants are not discriminated against due to race, religion, or gender. Once qualified, patients are chosen depending severity and need for treatment in comparison to other applicants at this time. Only a limited number are chosen.

5. After the screening, the applicants file, including all screening information, will be presented to the ***Jerene's Wish*** Advisory Board for approval or denial. Occasionally, applicants are asked to be re-screened at a later date as a result of poor dental hygiene and/or other developmental issues.

6. Notification of approval, denial, or re-screening will be mailed to the applicant.

Once accepted for the *Jerene's Wish* program:

1. Upon acceptance, applicant or applicant's parent/guardian must pay the orthodontic treatment cost before treatment will be initiated.

2. Applicants must initial all statements on the Program Rules and Regulations (Pages 5 & 6) of the ***Jerene's Wish*** application prior to beginning orthodontic treatment.

3. Applicants must be willing to arrive on time at scheduled appointments, which will be between the hours of **10:00 am- 2:00 pm.**

4. If more than three brackets are broken off, for whatever reason, additional charges will apply (1-2 is normal for an 18-24 month treatment).

Treatment contract will be terminated if the following occurs:

- The patient misses more than two appointments without at least 24 hour notice, and no more than 4 missed appointments no matter the reason.
- The patient does not comply with the treatment instructions, i.e. wearing rubber bands.
- If more than 7 brackets are broken off (3 are allowed at no additional charge)
- Oral hygiene isn't maintained, as this can be damaging to the health of the teeth.
- The financial arrangements aren't being kept up with the office.   Note: If treatment is terminated for any reason, there is no refund.
- If ***Warford Orthodontics*** deems it otherwise advisable to discontinue treatment we may discontinue treatment of the patient at any time.

To apply for the *Jerene's Wish* Program:

- Submit application for ***Jerene's Wish,*** which is available via email, by telephone, or online at warfordorthodontics.com and click on Jerene's Wish at the top of the page.
- Essay referencing why you would like to be selected for the ***Jerene's Wish*** Program.
- The dental referral form.
- Signed consent form.
- A copy of your most recent federal tax form.
  - Note: For children of divorced parents: If you share joint custody or alternate claiming your child please include both parents' tax returns.

Through Jerene's Wish

Warford Orthodontics
1145 West Turnpike Avenue
Bismarck, ND 58501
(701) 255-1311 1-800-732-3768

Application for Orthodontic Treatment

To be completed by the applicant:

Date of Application:______________________________

Name:______________________________

First Middle Last

Date of Birth: ______________________ Sex: Male_______ Female_______

Telephone (Home):____________________Cell Phone:____________________

Email:______________________________

Home Address, City State & Zip:______________________________

School:______________________________Grade Level:______________________________

Hobbies and Interests: ______________________________

____

Applicant's family information (if applicant is a minor):

Father's Name:______________________________

Father's Address:______________________________

Father's Employer:_________________________Father's Phone Number:_______________

Mother's Name:______________________________

Mother's Address:______________________________

Mother's Employer:____________________Mother's Phone Number:___________________

Siblings (Include names and ages):______________________________

____

Below are some reasons why people get braces. Please check whether each reason has a lot, a little or nothing at all to do with you wanting braces:

	A Lot	**A Little**	**Not At All**
I am embarrassed about the way my teeth look.			
I have difficulty eating and /or drinking.			
I have pain in my mouth or jaw.			
People make fun of my teeth.			
I have difficulty talking.			
I am afraid to smile.			
I cannot clean my teeth very well.			
I cover my mouth when I talk or smile.			

Has anyone ever made comments about your mouth or teeth? Please explain:

____

____

____

____

Who will be bringing you to your appointments?________________________________

How did you become aware of the ***Jerene's Wish*** Program?

____

Program Rules and Guidelines

PLEASE NOTE: This opportunity for you or your child to receive assistance through *Jerene's Wish* is one that many people do not receive and we are very happy to make this possible. However, we will only provide treatment if you and your child fully cooperate with the treatment plan and guidelines. Carefully read the following items and initial, indicating clear understanding:

- ***Jerene's Wish***, a program of ***Warford Orthodontics***, provides orthodontic treatment only. Extractions, cleanings, oral surgery, or other treatment that may be necessary before, during or after orthodontic treatment are the financial responsibility of the patient, patient's parents or legal guardians. **Initial _______**
- If you or your child has cavities or periodontal disease, these conditions must be completely remedied before treatment is started. **Initial _______**
- You or your child must continue to have regular dental visits and cleanings at least every six months during the orthodontic treatment. Making and keeping these appointments is your responsibility and failure to do so is grounds for termination. **Initial _______**
- During the course of treatment, if you or your child's teeth are not cleaned properly cavities can form around the braces. If teeth are not kept clean, or if cavities form and are not remedied, the orthodontist has the option to remove braces and end treatment. **Initial _______**
- If accepted, the patient, parents or legal guardian of the patient will be responsible for the investment of $1500 which must be **paid in full prior to treatment start**. This fee includes two set of retainers and all orthodontic records. **Initial _______**
- If accepted, treatment is only available through ***Warford Orthodontics***. If you move away from the area, funding will not be provided to a new orthodontist. **Initial _______**
- Regular orthodontic appointments are required to ensure teeth move as expected and no unwanted movement occurs. Therefore, it is your responsibility to make sure that all scheduled appointments are kept. Appointments will be scheduled between 10:00 am and 2:00 pm. Failure to meet this obligation of attending appointments on a regular basis is grounds for the orthodontist to remove the braces and terminate treatment. **Initial_______**
- You and or your child must fully comply with the treatment plan set by your orthodontist, which will be explained to you prior to treatment. **Initial _______**
- If braces are removed early due to noncompliance, payments made to date will not be refunded. **Initial _______**

- Broken appliances or loose brackets or bands can cause damage to teeth and the rest of the mouth. Therefore, you or 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 orthodontist has the option to remove the braces or charge you for repairs. **Initial _______**

- If treatment is approved, it is required that we have your consent to use your name, your child's name, case history, photographic images and quotes for any fundraising and/or promotional/business purposes in order to provide this service to other children in need. **Initial _______**

- It is required that you and your child agree to participate in surveys and case management during and after the course of orthodontic treatment, up to 24 months. **Initial ______**

The undersigned, being the custodial parent or legal guardian of _________________ ______________________________ has read and understands the information setting forth all the rules and guidelines to receive orthodontic treatment through *Jerene's Wish*. I have been given the opportunity to ask questions about this information. I understand that the awarding of *Jerene's Wish* for my child's orthodontic care is based on our ability to maintain our child's dental health, as indicated above, and to abide by all the rules and guidelines. I also understand that if our ability or desire to maintain dental health, or to abide by these rules and guidelines are not met, as indicated above, the braces will be removed and treatment will be terminated. I further consent and agree that if treatment is stopped and my child is removed from the program for not complying with the rules and guidelines, we will hold *Jerene's Wish/Warford Orthodontics* harmless and free from any liability for any damage and/or injury resulting from the termination of said treatment. If approved, I hereby consent to allow Jerene's Wish and its partner, *Warford Orthodontics*, to provide treatment for my child. The patient and his custodial parent(s) and/or legal guardian(s) agree that the services being rendered are being rendered at a greatly reduced rate or fee, and in consideration thereof hereby waive any and all claims against *Warford Orthodontics* for dental malpractice, negligence and/or any other potential legal claims whatsoever.

CUSTODIAL PARENT OR LEGAL GUARDIAN

Custodial Parent/Legal Guardian Signature _________________________________

Custodial Parent/Legal Guardian Printed Name __________________________________

Date:____________________

PATIENT (Child/Applicant) CONSENT

Patient named below is the above designated recipient of treatment through *Jerene's Wish* and also agrees to be bound by the *Jerene's Wish* rules and guidelines.

Child/applicant signature: ____

Child/applicant signature printed: ____

Please maintain a copy of this signed consent for your records.

Warford Orthodontics
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(701) 255-1311 1-800-732-3768

Dental Referral Form

Patient: ____
FIRST MIDDLE INITIAL LAST

Home Address: ____

Referring Dentist: ______________________**Telephone:** ____________________

FUNCTIONAL: **Date of visit:** ____________

Malocclusion:	Class I		Class II		Class III	
Crowding:	Mild		Moderate		Severe	
Spacing:	Mild		Moderate		Severe	
Overjet:	Mild		Moderate		Severe	
Overbite:	Mild		Moderate		Severe	
Crossbite:	Anterior		Posterior		Severe	

Good oral hygiene: Yes No	**Caries free:** Yes No	**Physically capable of cleaning teeth:** Yes No
Positive attitude toward dental care: Yes No	**Ability to complete treatment:** Yes No	**Keeps scheduled appointments:** Yes No
Impacted teeth: Yes No	**Missing teeth:** Yes No	**Date of First Visit:**

Other Functional or esthetic Problems/Comments: ____________________

____

Referring Dentist Signature & Date

____