



SHARE A SMILE APPLICATION

Applicant Name: _____ Age: _____ Gender: male female

Parent(s)/Guardian(s) Name: _____

Address: _____

Email Address: _____

Reason for Eligibility: _____

Parent(s)/Guardian(s) place of employment: _____

Responsible Party Phone Number: Home: _____ Cell: _____

Further information why this applicant is eligible for the Share a Smile Program: _____

Application Submitted by:

Please mail completed form to:

The Share a Smile Program
Shasta Orthodontics
68 Hartnell Ave
Redding, CA 96002