Genesis Dental Community Give Back Patient Application

Please describe why you (or the person you are nominating) are a good candidate for Genesis Dental's Charitable Dental Program. Include financial situation, other challenges, and any information you feel is relevant for consideration.

Transportation / Location Information

Can patient provide own transportation? ☐ Yes ☐ No

At which offices can patient be seen? (check ALL that apply) ☐ Magna ☐ Riverton ☐ Salt Lake ☐ T'Ville ☐ Tooele ☐ Orem

Can patient be seen any day Monday thru Friday? ☐ Yes ☐ No If no then specify days available _____

Can patient be seen anytime between 7 am and 5 pm? ☐ Yes ☐ No If no then specify times available _____

Patient Information

Date_____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Student ☐ Child

Last Name_____ First Name_____ Middle_____

Date of Birth_____ Social Security Number_____

Address _____ City _____ State _____ Zip _____

E-Mail _____ Home #_____

Work #_____ Cell # _____

Responsible Party Information

Last Name_____ First Name_____ Middle_____

Date of Birth _____Social Security #_____ Relationship to Patient_____

Address _____ City _____ State _____ Zip _____

Home #_____ Work #_____ Cell # _____

Employer _____ Phone # _____

How did you hear about our Charitable Dental Program? _____

Dental Information

Do your gums bleed when you brush?	☐ Yes	☐ No	Are your teeth sensitive to heat or cold?	☐ Yes	☐ No
Are your teeth sensitive to Pressure?	☐ Yes	☐ No	Do you have a fear of the dentist?	☐ Yes	☐ No
Do you grind or clench your teeth?	☐ Yes	☐ No	Have you had your teeth bleached before?	☐ Yes	☐ No

Date of Last Examination _____ What was done at that time?_____

Please describe the nature of patient's current dental needs, as you understand them

Please fill out this form and send it to Genesis Dental Corporate Office

Address – 6087 So. Redwood Rd., Suite C, Taylorsville, Utah 84123 Fax 801-285-9170 E-Mail karen@genesisdental.net