PURPLE HEART SMILES APPLICATION

Please fill out all information completely.

Child's Name: ______________________________ Child's Date of Birth: ____________

Veteran's Name: ______________________________ Veteran's Date of Birth: ___________

Active or Retired Military (circle one)

Dates of Service: __________________________ Branch: __________________________

Phone Number: ______________________ Email Address: __________________________

Mailing Address: ____

City: __________________________ State: __________ Zip Code: _________________

Do you have orthodontic dental insurance? Yes or No (circle one)

Insurance Carrier Name: ____________________________ Phone: __________________

Policy Holder's Name: ____

Policy Holder DOB: _______________________ SSN: ____________________________

Documentation Needed: (enclose a copy of each with application)

___ DD214;

___ Purple Heart Certificate; and

___ Proof of being either the parent or legal guardian of the child

By signing below, you are agreeing that all information submitted by you to the Georgia School of Orthodontics is true and complete. We thank you for your service.

Name *(Please print)*: ____________________________________

Signature: ____ Date: _______________

Mail Application To: Georgia School of Orthodontics
Purple Heart Smiles
8200 Roberts Drive
Suite 550
Atlanta, GA 30350