



DENTAL CARE for CHILDREN with SPECIAL NEEDS Grottoes of North America - Humanitarian Foundation



TO BE FILLED OUT BY PARENT OR LEGAL GUARDIAN

Date _____ Sponsoring Grotto _____

Name of Child _____ Sex: Male or Female

Address _____
Street City State Zip Code

Phone Number _____
Area Code Number

Patient's Date of Birth _____
Father's Name _____ Social Security Number _____
Mother's Name _____ Social Security Number _____
Legal Guardian _____ Social Security Number _____
(If different than Parent)

Employer's Name _____

Hospital or Dental Insurance
Yes No If yes, list provider below:

Medicaid is NOT supplemented by this Program. If you are covered by Medicaid we cannot cover those costs.

Group Number _____
Physician's Name: _____
Address: _____
Phone: _____
State of General Health _____

Specified Medical Condition/Diagnosis covered by this program are:
1. Cerebral Palsy
2. Muscular Dystrophy and related neuromuscular diseases
3. Mental Retardation*
4. Dental Treatment for Organ Transplant recipients

Specified Medical Condition/Diagnosis _____
A. When Diagnosed _____
B. Hospitalization _____
C. Therapy _____

*Mental Retardation covers profound to 2 years developmentally overall delayed. When submitting under developmentally delayed, a letter signed by your physician or preferably a licensed school psychologist must accompany your application, stating degree of learning level. (Please don't send IEP reports)

Present Mental Age _____
Medications now in use: _____

Were you referred by Shrine Hospitals/ Yes _____
Were you referred by Special Olympics/ Yes _____

DR. OF SMILES:

Name: _____
Address: _____
Phone Number: _____



The undersigned acknowledges that he/she is selecting the Dentist of his/her choice and the Dentist has not been recommended by the Grottoes of N America - Humanitarian Foundation. Grottoes do not review either the credentials, expertise or abilities of any dentist. The undersigned acknowledges that he/she is selecting the dentist at his/her own risk. In addition the undersigned hereby releases and discharges Grottoes of N America-Humanitarian Foundation from all liability and claims arising out of or related to the selection of any dentist or the provision of services by that dentist. This release is freely and voluntarily given.

Form #1

Parent Signature: _____