



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 _____ Email: _____
Area Code Number (optional)

Patient's Date of Birth _____

Father _____ Social Security Number _____

Mother _____ Social Security Number _____

Legal Guardian _____ Social Security Number _____
(If different than Parent)

Employer's Name (primary coverage) _____

Hospital or Dental Insurance

Yes No If yes, list provider below:

Group Number _____

Primary Care Physician: _____

Address: _____

Phone: _____

State of General Health _____

Specified Medical Condition/Diagnosis _____

A. When Diagnosed _____

B. Hospitalization _____

C. Therapy _____

Present Mental Age _____

Medications now in use: _____

DR. OF SMILES (local Grotto representative):

Name: _____

Address: _____

Phone Number: _____



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

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

*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)

Were you referred by Shrine Hospitals / Yes _____

Were you referred by the MDA Network/ Yes _____

Were you referred by Special Olympics / Yes _____

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.