DENTAL CARE FOR CHILDREN WITH SPECIAL NEEDS
GROTTOES OF NORTH AMERICA – HUMANITARIAN FOUNDATION

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

Date:_____ Grotto:_____

Name of Child_____ Sex: Male or Female

Address_____
Street City State Zip

Phone Number_____ Email_____
Area Code Number

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)_____

Dental Insurance
Yes No If yes, list provider below:
_____
_____

Group Number_____
Primary Care Physician
_____ Phone:_____
State of General Health _____
_____

Specified Medical Condition/Diagnosis
_____
A. Wen Diagnosed_____
B. Hospitalization_____
C. Therapy_____
Present Mental Age_____
Medications now is use_____

If your child is covered by Medicaid we cannot cover any costs. **Our program only covers children up to the age of 18 yrs. old.**

Specified Medical Condition/Diagnosis covered by this program are:

1. Cerebral Palsy
2. Muscular Dystrophy and related neuromuscular diseases
3. Intellectually Delayed*
4. Dental Treatment for Organ Transplant recipients
5. Cleft Lip and Palate (through a Shriners Hospital Only)

*Intellectually Delayed covers profound to 2 year developmentally delayed. A signed letter from the physician or licensed school psychologist stating the delay must accompany the application.

DR. OF SMILES (local Grotto representative)

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

 Parent/Legal Guardian Signature_____