DENTAL CARE FOR CHILDREN WITH SPECIAL NEEDS
HUMANITARIAN FOUNDATION OF GROTTOES INTERNATIONAL

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. When 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 21 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 Humanitarian Foundation of Grottoes International. 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 Humanitarian Foundation of Grottoes of International 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/Legal Guardian Signature_____