DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

YELLOW

# Registration Form

**Name** _____ _____ ____
**(Last)** **(First)** **(MI)**

**Address:** _____ _____
**(Street and number)** **(City & state)**

_____ _____ _____ _____
**(Zip code)** **(Phone number)** **(Date of birth)** **(Male/female)**

_____ _____ _____
**County** **work/cell** **Social Security #**

**Parents/Caregiver Email:** _____

**Method of Payment: Cash__ Visa MasterCard___ Insurance___ Medicaid___**

**Carrier Name**_____ **Group No.**_____

**Employee/Subscriber name:** _____

**SS#**_____

**Date of Birth**_____

**Employer:** _____

**Group or Identification No.**_____

**Patient/Parent/Legal Guardian:** _____
**(Signature)**

**Patient/Parent/Legal Guardian:** _____
**(Please print)**

**Signature of Witness** _____

DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

GOLD

# Medical History

**Name:** _____

**Date of Birth:** _____ **Age:** _____

**Patient's Disability:** _____

**Physician Name:** _____ **Ph#** _____

**Address:** _____ **City/State/Zip**_____

**Date of last medical visit:** _____ **Reason:** _____

**Medications:**

_____ _____ _____

_____ _____ _____

**Is patient taking any form of cannabis? Yes ☐No ☐ If yes, please list below.**

_____

**Is patient allergic to any medications/foods/or other? Yes ☐ No ☐ If yes, please list below.**

_____

**Has patient ever been hospitalized? Yes ☐ No ☐ If yes, give approximate year and reason.**

_____

***To the best of my knowledge, all of the preceding answers are true and correct. If the patient has any change in his/her health history, or medications, I will inform the dentist at the next appointment.***

_____ _____ _____

**(Patient/parent/legal guardian)** **(Date)** **(Dentist signature)**

_____

**(Signature of Witness)**

**OFFICE USE ONLY BELOW THIS LINE**

_____

| Date | Medical History Update | Signature |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

GOLD

# Medical History Form# 2

Name: _____ Age:_____ Date: _____

Check Y for "YES" or N for "NO" for any of the following you have had in the past or now have

***CARDIOVASCULAR*** Y ☐ N ☐
Heart failure Y ☐ N ☐
Angina or chest pain Y ☐ N ☐
High blood pressure Y ☐ N ☐
Heart murmur Y ☐ N ☐
Mitral valve prolapse Y ☐ N ☐
Rheumatic fever Y ☐ N ☐
Congenital heart defect Y ☐ N ☐
Artificial heart valve Y ☐ N ☐
Arrhythmias Y ☐ N ☐
Heart pacemaker/defibrillator Y ☐ N ☐
Heart surgery Y ☐ N ☐
Other heart problems Y ☐ N ☐
Stroke Y ☐ N ☐
Aneurysm Y ☐ N ☐
Shortness of breath Y ☐ N ☐
Swollen ankles Y ☐ N ☐
Sleep on 2 or more pillows Y ☐ N ☐

***HEMATOLOGIC*** Y ☐ N ☐
Blood transfusion Y ☐ N ☐
Anemia Y ☐ N ☐
Hemophilia Y ☐ N ☐
Leukemia Y ☐ N ☐
Sickle cell disease Y ☐ N ☐
Bleeding tendencies Y ☐ N ☐

***NEUROLOGIC*** Y ☐ N ☐
Glaucoma Y ☐ N ☐
Hearing loss Y ☐ N ☐
Sever headaches Y ☐ N ☐
Fainting or dizzy spells Y ☐ N ☐
Epilepsy Y ☐ N ☐
Seizures or convulsions Y ☐ N ☐
Psychiatric treatment Y ☐ N ☐
Paralysis Y ☐ N ☐

***GASTROINTESTINAL*** Y ☐ N ☐
Stomach or intestinal ulcers Y ☐ N ☐
Gastritis / Colitis Y ☐ N ☐
Hepatitis Y ☐ N ☐
Liver disease Y ☐ N ☐
Yellow jaundice Y ☐ N ☐
Cirrhosis Y ☐ N ☐

***RESPIRATORY*** Y ☐ N ☐
Hay fever Y ☐ N ☐
Sinus trouble Y ☐ N ☐
Allergies/hives Y ☐ N ☐
Asthma Y ☐ N ☐
Emphysema Y ☐ N ☐
Bronchitis Y ☐ N ☐
Tuberculosis (TB) Y ☐ N ☐
Breathing difficulties Y ☐ N ☐

***DERMATOLOGIC***
Allergy to latex rubber/metal Y ☐ N ☐
Skin rash Y ☐ N ☐
Fever blisters Y ☐ N ☐
Mouth ulcers/canker sores Y ☐ N ☐

***ENDOCRINE***
Diabetes Y ☐ N ☐
Thyroid disease Y ☐ N ☐

***GENITOURINARY***
Kidney problems Y ☐ N ☐
Diabetes Y ☐ N ☐
Sexually transmitted disease Y ☐ N ☐
(Syphilis, Gonorrhea, Chlamydia, Herpes)

***MUSCULOSKELETAL***
Arthritis Y ☐ N ☐
Artificial joints Y ☐ N ☐
Bone disorders Y ☐ N ☐
Muscle disorders Y ☐ N ☐

***OTHER***
HIV-Positive Y ☐ N ☐
Drug addiction Y ☐ N ☐
Alcohol addiction Y ☐ N ☐
Tumor or cancer Y ☐ N ☐
X-ray or cobalt treatment Y ☐ N ☐
Chemotherapy Y ☐ N ☐
Organ transplantation Y ☐ N ☐
- Kidney Y ☐ N ☐
- Heart Y ☐ N ☐
- Others (list)_____ Y ☐ N ☐

_____

Use tobacco Y ☐ N ☐
Reaction to dental anesthesia Y ☐ N ☐
Reaction to general anesthesia Y ☐ N ☐
If yes, what type:_____
_____
Unexplained weight loss/gain Y ☐ N ☐

***WOMEN:***
- **Pregnant** Y ☐ N ☐
- **Breast feeding (currently)** Y ☐ N ☐
- **Use of oral contraceptives** Y ☐ N ☐

**Signature**_____ **Date**_____

DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED



# DENTAL HISTORY

Name: _____ Date: _____

►Is this his/her first dental visit? _____ if no, complete the following:

►Previous Dentist _____ Date of last visit_____

►What treatment was done? _____

►What was patient's reaction to visit? _____

►Last complete series of x-rays? _____

►Who brushes his/her teeth? _____ How often_____

►Does he/she recognizes words such as: circle- mouth, teeth, open, close.

►Does he/she exhibit any of the following habits? Yes or no

Thumb sucking_____ finger biting_____

Rocking or fidgeting_____ physical resistance_____

►Does he/she use specific methods of communication other than speech to express needs and desires? _____

►How do you encourage or reward good behavior at home?

_____

►Does he/she respond favorably to physical contact and reassurance from family members? _____

►Is there any additional information that might help us in treating the patient?

_____

DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

GREEN

# CONSENT FOR TREATMENT

I consent to general dental treatment for myself/minor child which in the judgement of the dentist is necessary for oral health. This treatment may include but is not limited to the following: restoration of teeth, extracting of teeth, x-rays, administration of drugs/local anesthetics, root canals, periodontal treatment, prosthetics, oral surgery and other specialty treatments deemed necessary. I approve the release of my records to my insurance/Medicaid or other dentists as deemed necessary by the dentist. I authorize you to verify employment, financial or medical history, and other related matters as may be necessary to determine eligibility. I authorize the dentist to file claims and receive reimbursement directly from Medicaid/Peachcare for Kids. I understand that this request for dental treatment is valid for as many years as my child is eligible, by the program policy, for this service. This permission can be revoked only by written notification to:

The DDD Foundation, Inc.
52 Executive Park South, Suite 5203, Atlanta, Ga. 30329

I further verify that the above medical history is true and accurate to the best of my knowledge.

Date: _____ Patient: _____

Signature: _____ _____
(Relationship to Patient)

_____ _____
(Witness) (Relationship)

Verbal Consent Given By: _____

GREEN

DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED



# Consent for Physical Restraints

**"Physical Restraint by Dentist/Assistants: The restraining of the patient from undesirable movement by stabilizing the patient's hands, upper body, head and leg movements with the intention of preventing injury to the patient and dental staff."**

It is our intent that all professional care delivered in this office shall be of the best possible quality we can provide for our patients. Providing a high quality of care can sometimes be made very difficult, or even impossible, due to a lack of cooperation from the patient. The following behaviors that can interfere with the proper provision of quality dental care include: hyperactivity, resistive movements, refusing to open the mouth, kicking, screaming and grabbing the dentist's hands or sharp instruments.

I hereby give my consent to the doctors and the dental auxiliary staff, to use physical restraints including, but not limited to: a mouth prop, rainbow wrap, soft wrist restraints, leg and head restraints as an essential part of efforts to render mutually agreed upon dental services for the patient. I understand that periodontally compromised teeth may be dislodged with use of the mouth prop or molt. I further agree that this consent shall remain in full force unless withdrawn in writing by the person who has signed below on behalf of the patient.

Parent/Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

# Financial Policy

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Feel free to ask about our fees, Financial Policy, or your financial responsibility.

If you have dental insurance, we will help you receive your maximum allowable benefit. Dental insurance is a contract between you and your insurance company. It is your responsibility to understand the extent and limits of your coverage. It is not our place to enter into disputes between you and your insurance company regarding your benefits, other than to provide factual treatment information. Our staff will help you process whatever paperwork is required, however the ultimate responsibility lies with you for any balance due.

I UNDERSTAND THAT IF MY PRIMARY DENTAL INSURANCE PAYS MORE THAN THE ALLOWED AMOUNT RECOMMENDED BY MEDICAID, MEDICAID WILL NOT PAY THE DIFFERENCE AND THAT I AM RESPONSIBLE FOR THE REMAINING BALANCE.

WE ARE NOT A PARTICIPANT OF ANY DENTAL PLAN EVEN THOUGH YOUR REFERRING DENTIST MAY VERY WELL BE AND HAS REFERRED YOU TO OUR OFFICE FOR TREATMENT.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT. RETURNED CHECKS AND BALANCES OLDER THAN 60 DAYS WILL BE SUBJECT TO BEING TURNED OVER TO A COLLECTION AGENCY.

My signature below indicates that I have read and understand the financial policy as stated above and agree to accept responsibility as described. I understand that regardless of my insurance status, I am ultimately responsible for payment of my account.

**PARENT/GUARDIAN/PAYEE INFORMATION ONLY**

_____ _____
Parent/Guardian/Payee Name Phone number

_____
Address

_____ _____
Parent/Guardian/Payee Social Security # DOB

_____ _____
Signature of parent/guardian/payee Date

DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

# MOTOR SKILLS QUESTIONAIRE

Name: _____ Date: _____

Language spoken: _____

**Physical Coordination:**

| | | | | |
|---|---|---|---|---|
| Sitting: | none___ | poor___ | fair___ | good___ |
| Speech: | none___ | poor___ | fair___ | good____ |
| Vision: | none___ | poor___ | fair___ | good___ |
| Walking: | none___ | poor___ | fair___ | good___ |
| Balance: | none___ | poor___ | fair___ | good___ |
| Hearing: | none___ | poor___ | fair___ | good___ |
| Grasping: | none___ | poor___ | fair___ | good___ |
| Standing: | none___ | poor___ | fair___ | good___ |

Is patient in a wheel chair: yes _____ no _____

Neurologist: _____ Ph: _____

Cardiologist: _____ Ph: _____

Pharmacy: _____ Ph: _____

Allergies: _____

Weight: _____

DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

**Consent to Leave Messages or**
**Share Information with Family Friends**

**Consent for Leaving Messages**

_____ I consent to information regarding me or my child's appointment reminders/instructions, prescription information, and dental estimates be left on my voice mail or answering machine. I understand that "sensitive" information as noted below will be excluded.

**Consent for Shared Information with Family, Care Providers, Agency Representatives**

_____ I wish family members, care providers, and agency representatives to have access to my healthcare information.

Provide Name(s) of authorized individuals:

| Name | Relationship |
|---|---|
| 1._____ | _____ |
| 2._____ | _____ |
| 3._____ | _____ |

_____ _____
Print Signature

_____
Date

_____ _____
Witness Signature

DDD FOUNDATION, INC.

DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

# ACKNOWLEDGEMENT OF RECEIPT OF DOCUMENTS

****You May Refuse to Sign This Acknowledgement****

- Notice of Privacy Practices
- Patient Rights & Responsibilities
- Consent to Leave Messages

I, _____, have received a copy of this office's Notice of Privacy Practices, Consent to Leave Messages as well as Patient Rights & Responsibilities.

_____
Print name

_____ _____
Signature Date

---

**FOR OFFICE USE ONLY**

---

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

DDD FOUNDATION, INC.

DENTISTRY FOR THE
DEVELOPMENTALLY DISABLED

# PHOTO & INFORMATION RELEASE FORM

***I hereby grant to the DDD Foundation, Inc the absolute right and permission to use photographs/vid educational or promotional purposes. To use my name or the name of the minor on whose behalf I a signing, and/or other personally identifying facts, data, or information (including but not limited to I care treatment provided to me) obtained in a professional capacity in connection with the forgoing.***

***The undersigned completely and forever releases any right to present or future compensation in connection with the said photographs/slides.***

***Patient's Name _____***

***Parent/Responsible Party's Signature _____ Date _____***

***Relationship to Patient _____***

***Witness _____ Date_____***