DENTAL CARE FOR CHILDREN WITH SPECIAL NEEDS

Humanitarian Foundation – Grottoes of North America

All Treatment must be Pre-authorized, except initial exams, prophy, fluoride, xrays

Any Treatment over $1,000, MUST have Xrays submitted. If not, please explain.

ATTENDING DENTIST PRE-TREATMENT ESTIMATE

Form: #2

Sponsoring Grotto ________________________ Handicapping Condition ______________________

Child's Name ____ Sex: Male or Female Birthdate ___________________

Address____
Street City State Zip Code

Parent's Name ___________________________________ Social Security # __________________ Gross Income ____________

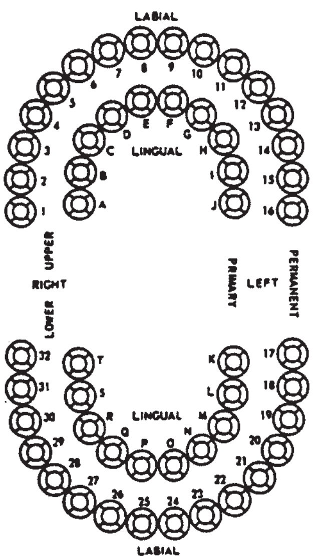
Dentist's Name ____ License No. _____________________

Tax ID No. ________________________

Dentist's Address ____(____)________________
Street City State Zip Code Phone Number

X Rays are attached: Yes No If this is a Prosthesis, Is this Initial Placement? Yes No

If NO, Reason for Replacement ____ Date of Prior Placement: _________________



INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES

Were you referred by Special Olympics?
Yes _____ No _____

EXAMINATION AND TREATMENT RECORD — USE CHARTING SYSTEM SHOWN

Tooth # Or Letter	Surfaces	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	Date Service Performed Mo. Da. Yr.	ADA PROCEDURE NUMBER	FEE	FOR CARRIER USE ONLY

ADDITIONAL INFORMATION: OR ATTACH - IN DUPLICATE			
	TOTAL FEE ACTUALLY CHARGED		
	Patient Pays		
	Balance		
	Carrier %		
	Carrier Pays		

I HAVE REVIEWED THE FOREGOING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

____________________________________(Parent/Guardian)

IF THIS IS A HOSPITAL CASE PLEASE LIST THE FOLLOWING ESTIMATED COSTS FOR PRE-AUTHORIZATION

Hospital __________________________________ Estimated Time for Treatment: ___________ Date of Treatment __________

Address____
Address City State Zip Code

Doctor's fee, including examination, surgery : $________________ Anesthesia $________________

Hospitalization (Ward or Semi Private) $________________ Partial of Denture $________________

Operating Room $________________ Miscellaneous (Lab, fee, etc.)$________________

Recovery Room $________________ TOTAL: $________________

ANY MONEY RECEIVED FROM INSURANCE, ETC., IS TO BE DEDUCTED FROM BILL BEFORE SUBMITTING FOR REVIEW AND PAYMENT

MEDICAID/MEDICAL CARD ARE PAYMENT IN FULL

Grotto Representative ________________________________ Dentist's Signature ____________________________________

Return to Dr. of Smiles for signature, he will mail paperwork to the Humanitarian Foundation Office for processing. SIGNATURES ARE REQUIRED