



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. When Diagnosed _____

B. Hospitalization _____

C. Therapy _____

Present Mental Age _____

Medications now is use _____

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 services by that dentist. This release is freely and voluntarily given.

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.

