SPECIAL SMILES
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IMPORTANT…
This form will not be accepted if incomplete.

1. Patient Name: _____ Sex (circle): Male Female

2. Date of Birth: _____ If under age 8, referral is required from previous dentist.

3. Social Security Number: _____

4. Insurance Name: _____ Member ID: _____
(If patient is covered by more than one insurance please note, and define which is primary and which is secondary):

5. Name of Facility/Agency (if any): _____

6. Address (Street Address/City/State/Zip): _____

_____

7. Does the patient live at residence by themselves: **a. Yes** **b. No** (If yes, be advised that after receiving general anesthesia patient would need to continuously be observed for 24 hours.)

8. Contact Name: _____ Relationship to Patient: _____

9. Contact Telephone: _____ **9**. Secondary (Cell) _____

10. Name of Legal Guardian: _____ **11**. Name of Person who Signs Consents: _____
If patient signs their own consents, then it must be witnessed by Director of the facility or if home patient, by an adult family member.

12. Previous Referring Dentist and phone number: _____

13. Primary Care Physician and phone number: _____

14. List all medical diagnoses/conditions: _____

15. Patient Weight: _____lbs. Patient Height _____*ft.*_____*in. (Patient eligibility is determined by their Weight/BMI)*

16. Is the patient experiencing oral pain, swelling or redness? Please circle: **a. Yes** **b. No** *(if yes, please proceed to the nearest emergency department for urgent treatment and then contact Special Smiles, Ltd. the next business day in order to schedule an initial consultation.)*

17. Is the patient edentulous (without teeth)? Please circle: **a. Yes** **b. No**

18. Date of last Dental Visit: _____ Is the patient cooperative for dental treatment (please circle) **a. Yes** **b. No**

19. Was dental treatment completed while patient (please circle) **a. was awake** **b. with sedation** **c. under general anesthesia**

20. What type of dental treatment was completed? _____

21. Are there any contraindications to general anesthesia? _____

22. Are there any medical and/or dental concerns that need to be addressed at the initial consultation? _____

_____

23. Which of the following describes the patient? Please circle: **a. in a wheelchair** **b. in a stretcher** **c. completely mobile**

***Please note that Special Smiles does not provide transportation to/from the appointment. Transportation is the responsibility of the individual's Facility/Guardian.**