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______________

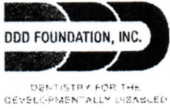
Employer: _____________________

Group or Identification No.________________

Patient/Parent/Legal Guardian: ______________________________
(Signature)

Patient/Parent/Legal Guardian: ____________________________
(Please print)

Signature of Witness ___________________________________



Medical History

Name: ______________________________

Date of Birth: ____________ Age: ______

Patient's Disability: ______________________________

Physician Name: ____________________ Ph# ________________

Address: ____________________ City/State/Zip________________

Date of last medical visit: __________ Reason: ________________

Medications: daily, prn/as needed, over-the-counter.

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

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)

Rev. 3/23

GOLD

DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

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

- 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 ☐

HEMATOLOGIC Y ☐ N ☐

- Blood transfusion Y ☐ N ☐
- Anemia Y ☐ N ☐
- Hemophilia Y ☐ N ☐
- Leukemia Y ☐ N ☐
- Sickle cell disease Y ☐ N ☐

NEUROLOGIC Y ☐ N ☐

- Glaucoma Y ☐ N ☐
- Hearing loss Y ☐ N ☐
- Sever headaches Y ☐ N ☐
- Fainting or dizzy spells Y ☐ N ☐
- Epilepsy or seizures 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 ☐
- Feeding Tube Y ☐ N ☐

RESPIRATORY Y ☐ N ☐

- Seasonal Allergies Y ☐ N ☐
- Allergies/hives Y ☐ N ☐
- Asthma Y ☐ N ☐
- Emphysema/Bronchitis Y ☐ N ☐
- Tuberculosis (TB) Y ☐ N ☐
- Breathing difficulties Y ☐ N ☐
- History of Aspiration Y ☐ N ☐

- Sleep Apnea Y ☐ N ☐

DERMATOLOGIC

- Allergy to latex rubber/metal Y ☐ N ☐
- Skin rash/skin condition Y ☐ N ☐
- Fistula/Graft Y ☐ N ☐
- Mouth ulcers/canker sores Y ☐ N ☐

ENDOCRINE

- Diabetes Y ☐ N ☐
- Thyroid disease Y ☐ N ☐

GENITOURINARY

- Kidney problems Y ☐ N ☐
- Dialysis 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

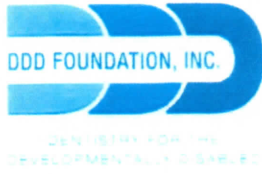
- HIV-Positive Y ☐ N ☐
- Drug/Alcohol addiction Y ☐ N ☐
- Tumor or cancer Y ☐ N ☐
- X-ray or cobalt treatment Y ☐ N ☐
- Chemotherapy Y ☐ N ☐
- Organ transplantation Y ☐ N ☐
  - Kidney Y ☐ N ☐
  - Heart Y ☐ N ☐
  - Others (list)__________ Y ☐ N ☐
- Use tobacco Y ☐ N ☐
- Reaction to dental anesthesia Y ☐ 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: ______________________

GOLD



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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?

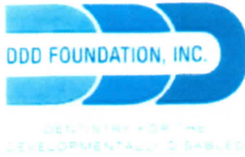
____

► 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?

____

BLUE



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.
3103 Clairmont Road NE, Suite C, 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: ___________________________

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: ________

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 ______________________

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: __________

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

3103 Clairmont Rd NE, Suite C Atlanta, GA 30329 | Phone 404-942-0086 | Fax 404-942-0088 | www.dddfoundation.org

ACKNOWLEDGEMENT OF RECEIPT OF DOCUMENTS

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

- o Notice of Privacy Practices
- o Patient Rights & Responsibilities
- o 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:

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

____

____

DENTISTRY FOR THE
DEVELOPMENTALLY DISABLED

PHOTO & INFORMATION RELEASE

I hereby grant to the DDD Foundation, Inc the right and permission to use photographs/videos for educational or promotional purposes, to use my name or the abbreviated name of the patient on whose behalf I am signing, and/or other personally identifying facts, data, or information (including but not limited to non-sensitive information about the health care treatment provided to me).

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

Patient's Name ______________________________

Parent/Responsible Party's Signature ______________________ Date __________

Relationship to Patient ______________________

Witness ______________________ Date__________

TESTIMONIAL RELEASE

I hereby authorize DDD Foundation, Inc. and staff to use any testimonial I may give and any information contained herein in its public relations efforts.

I understand that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in the patient's medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release DDD Foundation, Inc. from any and all claims for damages of any kind based on the use of my testimonial or information in the testimonial. By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Testimonial.

Patient's Name ______________________________

Parent/Responsible Party's Signature ______________________ Date __________

Relationship to Patient ______________________

Witness ______________________ Date__________

New Patient Demographics Information

Please fill out every blank.
The DDD Foundation uses this information ONLY to compile demographic data to apply for grant funding.
Patient's Information is NEVER shared.

Patient's Name: ____

Primary Developmental Disability: ______________________________________

Date of Birth: __________________________

Gender: _____Male _____Female

Mailing Address: ____

City: __________________________ State: ______ ZIP: ______________

County: _____________________________

Email: ____

I would like to receive occasional emails about DDD Foundation activities and events: ___N ___Y
(must provide email address above. If you do not mark either one, you will receive newsletters)

Patient Lives With: Parent(s)____ Caregiver/Guardian____ Group Home____ Self ____