Tufts Dental Facility for Special Needs
Richard & Susan Smith Family Foundation Dental Center
Seven Hills at Groton
22 Hillside Avenue
Groton, Massachusetts 01450
Phone: (978) 448-3388 Ext.354
Fax: (978) 448-2695

To Whom It May Concern:

Welcome to Tufts Dental at the Richard & Susan Smith Family Foundation Dental Clinic. Enclosed is your New Patient Packet. Please be aware that we are a special needs facility and all patients must fit the criteria.

This packet must be completed in its entirety and returned to Tufts Dental. Because appointments will not be made until the entire packet is received, please return all documentation together as a packet and not at different times. Packets may be mailed or delivered to us. Initial packets should not be faxed.

Please include:

1. Medical Health History Form must be completed/signed by a health care provider (MD, PA, RN, or LPN).

2. Patient Information Form must be completed by parent/case/house/program manager.

3. Court Decree stating guardianship (not the petition) if applicable.

4. Copies of front and back of Masshealth and/or any other insurance cards.

5. Signed Release Form allowing Tufts Dental to contact PCP regarding any needs or questions.

Please remember that no appointments will be scheduled if any of these applicable papers are not completed in their entirety.

Thank you,
Tufts Dental
Tufts Dental Facility for Special Needs
Richard & Susan Smith Family Foundation Dental Center
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22 Hillside Avenue
Groton, Massachusetts 01450
Phone: (978)448-3388 Ext. 354 Fax: (978)448-2695

To Our Patients and Their Care Providers:

To better serve our patient population, and to ensure continuity of treatment, we would like to remind and reinforce to you our clinic policies. They are as follows:

1. For patients 18 years or older who have a court appointed guardian, please submit a copy of the court decree for guardianship. This will ensure communication between dental care providers and guardians, and timely treatment.

2. To cancel an appointment, please give us a 24 hour minimum notice. This way we can reschedule the patients appropriately, and ensure continuity of care. (Appointments missed without notification or cancelled in less than 24 hours is a broken appointment).

3. If a patient fails appointments without notification repeatedly (three times or more during the year), or does not come to our clinic for 2 years, he/she will be considered an inactive patient. To avoid this, we will send you written notification so care providers can respond.

4. Patients who arrive more than 10 minutes late for their appointment will be accommodated to the best of our abilities, but may have to rescheduled if not enough time is available in order to serve other timely patients in the daily schedule.

Dental health plays an important role in a patient’s overall health. With your cooperation, we the providers, want to give our patients continuous treatment personalized to their needs. Please let us know you have any questions or concerns.

Thank you

Tufts Dental
# Medical Health History

**To Be Completed by Health Care Practitioner or Nurse**

Please complete all questions in full including yes and no answers.

<table>
<thead>
<tr>
<th>Patient’s Last Name:</th>
<th>Patient’s First Name:</th>
<th>DOB:</th>
</tr>
</thead>
</table>

**Today’s Date:** MONTH: DAY: YEAR:

Printed name of health care practitioner or nurse completing form:

Signature:

Address:

Telephone:
Fax Number:

Date of last physical: Height: Weight:

Patient’s Medical Diagnosis/Disability:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Does the patient require SBE premedication?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>If yes, please list name of drug and dosage:</td>
</tr>
</tbody>
</table>

| YES | NO | Does the patient need to be premedicated before dental treatment? |
|-----|----|If yes, please list name(s) of drug(s) and dosage:|

| YES | NO | Has the patient ever been hospitalized? |
|-----|----|Has the patient ever had surgery? |
| YES | NO | Has the patient ever had general anesthesia? |
| YES | NO | Has the patient ever had complications with general anesthesia? |
|     |    | If yes, please explain the complications: |

| YES | NO | Does the patient have any Drug Allergies? |
|-----|----|If yes, please list the Drug Allergies: |

| YES | NO | Does the patient have any other Allergies? |
|-----|----|If yes, please list any other Allergies: |

| YES | NO | Alcohol Use |
|-----|----|Alzheimer’s Disease |
| YES | NO | Anemia |
| YES | NO | Angina |
| YES | NO | Arthritis |

Page 1 of 3
<table>
<thead>
<tr>
<th>PATIENT'S NAME:</th>
<th>DOB:</th>
</tr>
</thead>
</table>
| YES | NO | Artificial hips, pins/rods  
If yes, please specify where: |
| YES | NO | Aspiration Problems |
| YES | NO | Asthma |
| YES | NO | Autism |
| YES | NO | Bisphosphonate Use (For osteoporosis or for other reasons) (i.e. Fosamax) |
| YES | NO | Bleeding Problems |
| YES | NO | Blood Thinners |
| YES | NO | Blood Transusions |
| YES | NO | Bone Joint Problems |
| YES | NO | Brain Injury |
| YES | NO | Cancer  
If yes, please explain type of Cancer: |
| YES | NO | Cerebral Palsy |
| YES | NO | Cleft lip/Palate |
| YES | NO | Diet Considerations |
| YES | NO | Chronic Ear Infections |
| YES | NO | Congenital Heart Disease |
| YES | NO | Convulsions/Seizures |
| YES | NO | Cystic Fibrosis |
| YES | NO | Diabetes |
| YES | NO | Dialysis |
| YES | NO | Down Syndrome |
| YES | NO | Dysphagia |
| YES | NO | Eating Disorder |
| YES | NO | Emotional disturbances |
| YES | NO | Endocrine Diseases |
| YES | NO | Epilepsy/Seizures  
If yes, please explain: |
| YES | NO | Gastrointestinal Disorder |
| YES | NO | GERD/Reflux |
| YES | NO | G-Tube/Tube Fed |
| YES | NO | Head Injury |
| YES | NO | Hearing Impairment |
| YES | NO | Heart Disease  
If yes, please explain type of Heart Disease: |
| YES | NO | Heart Murmur |
| YES | NO | Hepatitis/Liver Disease/Jaundice |
| YES | NO | Hemophilia |
| YES | NO | High blood pressure |
| YES | NO | HIV/AIDS |
## Medical Health History

**To Be Completed By Health Care Practitioner Or Nurse**

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>DOB:</th>
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<tbody>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>Implanted Devices (i.e. Defibrillator/VNS Implant)</td>
<td>If yes, please specify type of device:</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Infectious disease</td>
<td></td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Kidney disorder/disease</td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Leukemia</td>
<td></td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Mental retardation</td>
<td>If yes, please circle the following:</td>
</tr>
<tr>
<td>MILD</td>
<td>MODERATE</td>
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<tr>
<td>Please specify diagnosis if known:</td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td></td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Musculoskeletal/connective tissue disease</td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Muscular dystrophy</td>
<td></td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Neurological disorders</td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Nicotine/tobacco use</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Osteoporosis</td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>PICA</td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Psychological disorders</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Respiratory condition</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Rheumatic fever</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Shunt</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Skin condition</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Speech impairment</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Spina Bifida</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Spinal cord injury</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Stroke</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Syncope</td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Syndrome/condition</td>
<td>If yes, please name:</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Thyroid condition</td>
<td></td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Tonsil/Adenoid Infection</td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Tracheostomy</td>
<td></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>Transplant</td>
<td>If yes, please specify type of Transplant:</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Tube Fed</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Venereal disease</td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
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<tr>
<td>Visual impairment/eye problem</td>
<td></td>
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<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>WOMEN ONLY: Is the patient pregnant?</td>
<td></td>
</tr>
</tbody>
</table>

If YES to any of the above, please explain:

**Any Additional Comments:**
# PATIENT INFORMATION FORM

TO BE COMPLETED BY PARENT OR CASE/HOUSE/PROGRAM MANAGER

<table>
<thead>
<tr>
<th>Today’s Date:</th>
<th>Male</th>
<th>Female</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td></td>
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<tr>
<td>First Name:</td>
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<tr>
<td>Middle Initial:</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Nickname:</th>
<th>SS #:</th>
<th>DOB:</th>
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<table>
<thead>
<tr>
<th>Street Address:</th>
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<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>ZIP Code:</th>
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<table>
<thead>
<tr>
<th>Home Phone #:</th>
<th>Cell Phone #:</th>
<th>Email Address:</th>
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**Patient’s Legal Guardian(s): Please list all guardian(s) information if applicable**

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Relation to Patient:</th>
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<table>
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<tr>
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<th>Email Address:</th>
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*We are required to have a copy of the court decree on file. Please submit with this form.*

**Person Financially Responsible for Patient:**

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Relation to Patient:</th>
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<tr>
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<th>Cell Phone #:</th>
<th>SS #:</th>
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**Patient’s Contact Person:**

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Relation to Patient:</th>
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<table>
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<th>Cell Phone #:</th>
<th>Email Address:</th>
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<td></td>
</tr>
<tr>
<td>PATIENT'S NAME:</td>
<td>DOB:</td>
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<td>----------------</td>
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</tr>
<tr>
<td>Is Patient a Ricci Class Member?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is Patient a D.M.R. Client?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If Yes, D.M.R. Service Coordinator’s Information:
- Last Name: 
- First Name: 
- Contact Phone #: 
- Address: 

Patient’s Primary Care Physician:
- Doctor’s Name: 

Physician’s Address: 
- Phone #: 
- Fax #: 

Patient’s Insurance Information: 
- MASSHEALTH NUMBER
  - New MMIS (Medicaid Management Information System) Member ID: 
    - / / / / / / / / / / / / / / / / 

Any Other Insurance: 
- Dental 
- Medical 
- Insurance Company Name, Address and Phone: 
- Subscriber’s Name: (First, Middle Initial, Last) 
- Subscriber’s Address, City, State, Zip 
- Subscriber’s Place of Employment 
- Subscriber’s I.D. #: 
- Subscriber’s Social Security Number: 
- Subscriber’s DOB: 
- Group/Policy #: 

Page 2 of 4
**PATIENT INFORMATION FORM**

**TO BE COMPLETED BY PARENT OR CASE/HOUSE/PROGRAM MANAGER**

**PATIENT’S NAME:**

**DOB:**

<table>
<thead>
<tr>
<th>How often does the patient brush?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
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<tr>
<td>YES</td>
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</tbody>
</table>

If the patient uses any additional oral hygiene aids please list:

| YES | NO | Do the patient’s gums bleed when brushing or flossing? |
| YES | NO | Is the patient’s water supply fluoridated? |
| YES | NO | Does the patient take any fluoride supplements? |
| YES | NO | Does the patient have difficulty with dental visits? |
| YES | NO | Has the patient ever been pre-sedated for any medical or dental appointment in the past? |

If so, what was the pre-sedation medication?

| YES | NO | Was the pre-sedation medication effective? |
| YES | NO | Are the patient’s teeth sensitive to food or liquids? |
| YES | NO | Are there any sores or lumps in or near the patient’s mouth? |
| YES | NO | Does the patient wear dentures or partials? |

<table>
<thead>
<tr>
<th>ORAL HABITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
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<tr>
<td>YES</td>
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<td>YES</td>
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<td>YES</td>
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<td>YES</td>
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<td>YES</td>
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<td>YES</td>
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<td>YES</td>
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</table>

<table>
<thead>
<tr>
<th>ADDITIONAL PATIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
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<tr>
<td>YES</td>
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<td>YES</td>
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<td>YES</td>
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<td>YES</td>
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</tbody>
</table>

**Printed Name and Signature of Person completing this form:**
PATIENT INFORMATION FORM
TO BE COMPLETED BY PARENT OR CASE/HOUSE/PROGRAM MANAGER

PATIENT'S NAME:
DOB:

PRESCRIPTIONS AND OVER THE COUNTER MEDICINES
PLEASE LIST BELOW OR ATTACH MED SHEET TO THIS FORM

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage/Frequency</th>
<th>Reason Prescribed</th>
<th>Name of Physician</th>
</tr>
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<tbody>
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</tbody>
</table>
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Richard & Susan Smith Family Foundation Dental Center
Seven Hills at Groton
22 Hillside Avenue
Groton, Massachusetts 01450
Phone: (978)448-3388 Ext. 354 Fax: (978)448-2695

Release Form

Date: ______________________

Dr. ______________________ Phone: ______________ Fax: ______________

Please be advised that ______________________ DOB ______________________
will be receiving dental services from Tufts University Dental in Groton Massachusetts. I give
permission for Tufts to contact you regarding any needs or questions that they may have.

____________________________________
Parent/Guardian Signature