Tufts UNIVERSITY | School of Dental Medicine

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

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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

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MEDICAL HEALTH HISTORY
TO BE COMPLETED BY HEALTH CARE PRACTITIONER OR NURSE

PLEASE COMPLETE ALL QUESTIONS IN FULL INCLUDING YES AND NO ANSWERS

Patient's Last Name:	**Patient's First Name:**	**DOB:**

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:

YES	NO	Does the patient require SBE premedication?
If yes, please list name of drug and dosage:		
YES	NO	Does the patient need to be presedated before dental treatment?
If yes, please list name(s) of drug(s) and dosage:		
YES	NO	Has the patient ever been hospitalized?
YES	NO	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
YES	NO	Alzheimer's Disease
YES	NO	Anemia
YES	NO	Angina
YES	NO	Arthritis

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PATIENT'S NAME: **DOB:**

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 Transfusions
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

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PATIENT'S NAME: **DOB:**

YES	NO	Implanted Devices (i.e. Defibrillator/VNS Implant) If yes, please specify type of device:
YES	NO	Infectious disease
YES	NO	Kidney disorder/disease
YES	NO	Leukemia
YES	NO	Mental retardation If yes, please circle the following: MILD MODERATE PROFOUND Please specify diagnosis if known:
YES	NO	Multiple Sclerosis
YES	NO	Musculoskeletal/connective tissue disease
YES	NO	Muscular dystrophy
YES	NO	Neurological disorders
YES	NO	Nicotine/tobacco use
YES	NO	Osteoporosis
YES	NO	PICA
YES	NO	Psychological disorders
YES	NO	Respiratory condition
YES	NO	Rheumatic fever
YES	NO	Shunt
YES	NO	Skin condition
YES	NO	Speech impairment
YES	NO	Spina Bifida
YES	NO	Spinal cord injury
YES	NO	Stroke
YES	NO	Syncope
YES	NO	Syndrome/condition If yes, please name:
YES	NO	Thyroid condition
YES	NO	Tonsil/Adenoid Infection
YES	NO	Tracheostomy
YES	NO	Transplant If yes, please specify type of Transplant:
YES	NO	Tuberculosis
YES	NO	Tube Fed
YES	NO	Venereal disease
YES	NO	Visual impairment/eye problem
YES	NO	WOMEN ONLY: Is the patient pregnant?
If **YES** to any of the above, please explain:		
ANY ADDITIONAL COMMENTS:		

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PATIENT INFORMATION FORM

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

Today's Date:	Male Female	Age:
Last Name:	First Name:	Middle Initial:
Nickname:	SS #:	DOB:
Street Address:		
City:	State:	ZIP Code:
Home Phone #:	Cell Phone #:	Email Address:
Patient's Legal Guardian(s): Please list *all* guardian(s) information if applicable		
Last Name:	First Name:	Relation to Patient:
Street Address:		
City:	State:	ZIP Code:
Home Phone #:	Cell Phone #:	Email Address:
We are required to have a copy of the court decree on file. Please submit with this form.		
Person Financially Responsible for Patient:		
Last Name:	First Name:	Relation to Patient:
Street Address:		
City:	State:	ZIP Code:
Home Phone #:	Cell Phone #:	SS #:
Patient's Contact Person:		
Last Name:	First Name:	Relation to Patient:
Street Address:		
City:	State:	ZIP Code:
Home Phone #:	Cell Phone #:	Email Address:

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PATIENT'S NAME: **DOB:**

Is Patient a Ricci Class Member?	Yes No	
Is Patient a D.M.R. Client?	Yes No	
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 #:		

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PATIENT'S NAME: **DOB:**

DENTAL HISTORY		
How often does the patient brush?		
YES	NO	Can the patient brush independently?
YES	NO	Does the patient use a powered/electric toothbrush?
YES	NO	Does the patient floss?
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?
ORAL HABITS		
YES	NO	Spastic Bite Reflex?
YES	NO	Sucks thumb or fingers?
YES	NO	Bites cheeks?
YES	NO	Chews or bites nails?
YES	NO	Chews hard objects?
YES	NO	Grinds teeth?
YES	NO	Clenches jaw?
YES	NO	Mouth Breather?
YES	NO	Gag Reflex?

ADDITIONAL PATIENT INFORMATION		
YES	NO	Can the patient become aggressive?
YES	NO	Does the patient exhibit self-abusive behavior?
YES	NO	Is the patient non-verbal?
YES	NO	Does the patient understand simple language?
YES	NO	Is the patient ambulatory?
YES	NO	Can the patient transfer to dental chair independently?
YES	NO	Does the patient use a communication board?
YES	NO	Does the patient wear glasses?
YES	NO	Does the patient wear hearing aid(s)?
Printed Name and Signature of Person completing this form:		

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PATIENT'S NAME: **DOB:**

PRESCRIPTIONS AND OVER THE COUNTER MEDICINES PLEASE LIST BELOW OR ATTACH MED SHEET TO THIS FORM			
Drug Name	Dosage/Frequency	Reason Prescribed	Name of Physician

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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