UNIVERSITY OF WASHINGTON

SCHOOL OF DENTISTRY
DEPARTMENT OF ORAL MEDICINE

Dear DECOD applicant:

Thank you for considering us for your oral health care needs. We look forward to receiving your application packet.

In order to process your application in a timely manner, please complete and return the following documents i n this packet and the summary report from Primary Care Physician.

Forms in packet

- ❑ Patient Registration Form (1 page)
- ❑ About You Form (2 pages)
- ❑ Health Questionnaire (2 pages)
- ❑ Medication List (1 page)
- ❑ Health Care Decisions Information (1 page)
- ❑ Consent for Routine Dental Treatment (1 page)
- ❑ Care Agreement (1 page)
- ❑ Financial Agreement (1 page)
- ❑ Notice of Privacy Practices Acknowledgment (1 page)

Forms to obtain from Primary Care Physician

❑ Annual Physical Examination Report (2-3 page summary)– Please obtain a copy for the most recent exam done within the last three years from your Primary Care Physician.

Other documentation to include

❑ *Copy of your Apple Health card and/or any other insurance information for your records, if applicable.* **Please be advised that Apple Health has enhanced dental benefits for adults with developmental disabilities who have a DD classification under the Medicaid program. Patients with a DD classification under Medicaid are typically eligible for DECOD services.**

PLEASE NOTE: Incomplete and unsigned documents may result in processing and approval delays.
PLEASE NOTE: Prolonged absences from the DECOD Clinic may require re-application to the program.

You may use the prepaid, self-addressed envelope when returning these required documents. Upon receipt, we will review your application for DECOD Program eligibility and contact you or your representative.

About the initial appointment: Zoom Teledentistry
If accepted as a patient, you will be given an initial appointment via Zoom Teledentistry for initial assessment. This will consist of two appointments: 1) new-patient intake **phone call**, and 2) Zoom Teledentistry. This helps us plan for how we can best support your needs when you come to the clinic in person.

Please see UW DECOD Clinic Teledentistry Appointment Guide for details of these two appointments.

In-person clinic appointment will be scheduled after completion of these two appointments. *Please plan ahead if you need assistance locating the clinic.*

Thank you for your application. We look forward to serving you.

Sincerely,
Renee Takeuchi, Patient Care Coordinator

UW Oral Medicine – DECOD Program
Health Sciences Building 1959 NE Pacific Street Room B323
Box 356370 Seattle, WA 98195-6370
Phone: 206-543-4619 Fax: 206-221-5276

University Of Washington

School of Dentistry

Dental Education In Care of Person with Disabilities (DECOD)

Patient Registration

Name: Last	*First*	*Middle*			*Date of Birth*	*Sex*
Address:	*Street*	*City*	*State*	*Zip*	*Home Phone*	
Social Security		*Occupation*			*Business Phone*	
Physician's Name					*Physician's Number*	
Physician's Address:						
Referred by- Name/Address Telephone Number						
Case Manager Name/Address/Telephone Number						
Parent's or Guardian 's name/address/Telephone number						
Emergency Contact- Name/Address/Telephone Number						
Method of Payment	*Insurance*				*Provider One Number*	
Will an attendant, guardian or Interpreter accompany you to the DECOD Clinic. What is his name						
What is your Disability? _____ *What was the cause of your disability?* _____ *How Long have you been disabled?* _____						

UW Dental Education in Care of People with Disabilities (DECOD)

Patient Name:_____ Date of birth: _____

Date form filled out: _____ Height: _____ Weight: _____

Havehad any of the following?

Surgery, serious Illness or hosipitalization? Please specify: _____

Yes No

_____

_____

_____

Yes No Radiation or Chemotherapy? Please specify: _____

_____

_____

Are you allergic to any medications, foods, or other substances?

Yes No If yes, please specify: _____

_____

Are you taking or have you taken the following?

Yes No Steroid Medications? Please specify: _____

_____

_____

Yes No Oral bisphosphonates?

Fosamax/Alendronate Didronel/Etidronate Boniva/Ibandronate

Actonel/Risdeonate Skelid/Tiludronate Other _____

Yes No IV bisphosphonates?

Bonefos/Clodronate Aredia/Pamidronate Reclast/ Zoledronic Acid

Zometa/Zolednronic Acid Other_____

Yes No Other Antiresorptive Bone Medications

Denosumab/Prolia/Xgeva Other _____

Yes No Blood thinners?

Coumadin/Warfarin Plavix/Clopidogrel bisulfate

Other _____

UW Dental Education in Care of People with Disabilities (DECOD)

Patient Name: _____ Date of birth:_____

Do you have any of the following diseases, problems or symptoms? Check all that apply.

Developmental or Intellectual Disability

- ☐ Intellectual disability
- ☐ Down syndrome
- ☐ Cerebral palsy
- ☐ Autism / ASD
- ☐ Other syndrome: _____
- ☐ Other developmental disability: _____

Neurologic or Nerve Problems

- ☐ Seizures / Epilepsy (describe): _____ _____
- ☐ Dementia
- ☐ Stroke or TIA
- ☐ Multiple sclerosis
- ☐ ALS
- ☐ Traumatic brain injury
- ☐ Parkinson's disease

Mental Health Condition

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Post-traumatic stress disorder
- ☐ ADD/ADHD
- ☐ Schizophrenia
- ☐ Anorexia
- ☐ Bulimia
- ☐ Pica
- ☐ Other: _____ _____

Vision, Hearing, Skin Conditions

- ☐ Blind
- ☐ Vision impairment
- ☐ Deaf
- ☐ Hearing loss
- ☐ Psoriasis
- ☐ Other: _____

Respiratory/Lung Problem

- ☐ Aspiration Risk
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Recurrent pneumonia
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Other _____ _____ _____ _____

Heart/Blood Pressure

- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Artificial heart valves
- ☐ History of heart surgery
- ☐ Heart attack
- ☐ Other _____ _____

Diabetes/Endocrine Condition

- ☐ Diabetes
  - ○ Type 1
  - ○ Type 2
- ☐ Hypothyroidism
- ☐ Hormone replacement
- ☐ Other thyroid disorder _____
- ☐ Other _____ _____ _____

Muscle, bone, connective tissue

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Taking bisphosphonates _____
- ☐ Other _____ _____

Women Only

- ☐ Are you pregnant?
- ☐ Are you trying to become pregnant?
- ☐ Are you nursing?

Blood/Hematologic and Cancer

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Deep vein thrombosis
- ☐ Cancer
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple myeloma
- ☐ Other _____ _____ _____

Immune and Infectious

- ☐ Immune compromise
- ☐ HIV
- ☐ AIDS
- ☐ Hepatitis _____
- ☐ MRSA
- ☐ Cold sores
- ☐ Other _____

Gastrointestinal and Kidney

- ☐ Heart burn / reflux
- ☐ GERD
- ☐ Chronic constipation
- ☐ Liver cirrhosis
- ☐ Chronic Hepatitis
- ☐ Renal failure
- ☐ Renal insufficiency
- ☐ Dialysis
- ☐ Other _____

Smoking, Alcohol, Drugs

- ☐ Do you smoke?
- ☐ Do you drink?
- ☐ Do you use drugs for recreational purposes?
- ☐ Do you have problems with alcohol or alcoholism?
- ☐ Do you/have you used
- ☐ Cocaine
- ☐ Marijuana
- ☐ Methamphetamine
- ☐ Other _____

UW Dental Education in Care of People with Disabilities (DECOD)

Patient Name:_____ Date of birth: _____

Medication List

Drug Name	Dosage	Frequency	Reason Taking

Consent for Routine Dental Treatment
UW School of Dentistry – DECOD Program

Information

Routine dental treatment **may include** examinations, xrays, cleanings and fluoride, fillings, sealants, dentures, and crowns, among others. It also includes the use of local anesthesia ("numbing" of the teeth and mouth). The care that is able to be provided in the clinic setting may be limited by the ability of the patient to tolerate treatment in an office setting. In such cases, your provider may recommend alternative forms of treatment depending on the treatment needs.

Routine dental care **does not include** surgery (such as the removal of teeth), general anesthesia, or medical immobilization (such as the use of a papoose board). If needed, additional consent(s) will be requested.

If you have **questions** regarding routine dental procedures, you may talk to your dental provider in-person during a dental appointment or over the phone by calling the DECOD clinic.

Consent

I consent to routine dental treatment for the patient named below.

I have had the chance to ask questions and have my questions answered regarding routine dental treatment.

If any unexpected problems arise during care, I further consent for the dental provider(s) to manage these conditions as needed.

I understand that this consent does not include consent for surgical procedures, general anesthesia, or medical immobilization. If needed, additional consent(s) will be requested.

I understand that I can withdraw this consent at any time. If consent is withdrawn during a procedure, my provider is authorized to find a safe stopping point prior to ending the treatment. To withdraw my consent, I will need to inform my dental provider(s).

_____
Patient's name (printed)

_____
Patient signature (**if own guardian**) Date

_____
Guardian signature (**if patient has guardian**) Date

Patient Name:_____ **Birth date:**_____

SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Care Agreement

This form contains facts you should know about your dental care at UW School of Dentistry (UW SOD). If there is any part of this form that is unclear you can ask questions about it. Your signature is required at the end of this form acknowledging that you have read this form (or had it read to you), have been offered a copy of the Patient Rights and Responsibilities brochure and agree to receive dental care from us and to the terms of this agreement.

UW School of Dentistry includes:

- Pre-DoctoralStudent Clinic
- Dental Urgent Care
- UW Dentists Faculty Practice
- Advanced General Dentistry
- Oral Medicine
- Dental Education in Care of Persons with Disabilities
- The Center for Pediatric Dentistry
- Dental Fears & Research Clinic
- Oral Maxillofacial Surgery
- Endodontic Clinic
- Periodontic Clinic
- Prosthodontic Clinic
- Orthodontics Clinic

Your dental care team consists of dentists, dentists in advanced training programs, dental students, dental assistants, dental hygienists, and other health care professionals. They will work together to diagnose and treat you. Photographs and other images of you may be used to keep a record of your care and treatment. These images may become part of your dental record.

Signature

By providing my email address to the UW School of Dentistry (UW SOD), I am authorizing the UW SOD to communicate via the email address provided regarding my/my child's care, appointments, special promotions and oral health information. I understand that UW SOD providers and staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that because email is not secure, there are associated risks that may affect the privacy of my personal health care information when using email to communicate. I understand that if I no longer wish to have my email address on file, I must give verbal notice to any of the front desk staff within the UW SOD and the information will be removed and my request notated on my account.

By signing below, I agree that I have have read this document and agree to receive healthcare from UW School of Dentistry.

SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE

IF SIGNED BY PERSON OTHER THAN PATIENT, CHECK RELATION TO PATIENT:

☐ 1. Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse/Registered Domestic Partner
☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

☐ 1. Guardian/Legal Custodian ☐ 2. Court-authorized person for child in out-of-home placement ☐ 3. Parent(s)
☐ 4. Holder of signed authorization from parent(s) ☐ 5. Adult representing self to be a relative responsible for the minor's health

Last revised Oct 21, 2016

Patient Name: _____ **Birth date:** _____

SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Financial Agreement

Thank you for choosing University of Washington School of Dentistry (UW SOD) for your dental care. We are committed to providing you quality and affordable dental care. The following information will help you understand how we work together and provide the information you need to meet your financial responsibilities for services you receive.

Dental and Medical coverage

Insurance coverage is a contract between you and your insurance company. You are responsible for knowing which services your insurance will cover before you receive care. If you're not sure about your insurance coverage, please ask your insurance company.

Insurance billing

- **Contracted coverage:** The School of Dentistry contracts with several insurance companies. If we are in your plan's network, our billing office will submit claims to your insurance company for the services you receive from us. You are responsible to pay co-pays or any portion not covered by your insurance at time of service.
- **Non-contracted:** If the School of Dentistry does not contract with your insurance plan, we will bill your insurance as a courtesy. You are responsible for payment at the time of service and your insurance company will reimburse you directly.

Services not covered by your insurance plan

Not all services are covered by your insurance plan. If you receive treatment that is not covered, you will be responsible for the full cost at the time of service.

Adult bringing a minor (under 18 years of age) for treatment

A parent or guardian who brings a minor to his or her appointment is responsible for any payments due at the time of service. If a responsible adult is not present, treatment that is not urgent may be rescheduled.

Missed appointments

If you miss an appointment, or do not cancel your appointment within 24 hours, we may charge you a cancellation fee. This fee is your responsibility and will be billed directly to you. Please note that chronic lateness to appointments or more than two cancelled or failed appointments may be cause for discontinuing your care at the School of Dentistry.

Billing

Payment for all bills is due within 30 days from date of service. You may pay by check, debit or credit card (Visa, MasterCard or Discover). If we do not receive payment, we will continue to send you bills until we receive payment in full. Unpaid balances may be referred to a collection agency.

By signing below, I agree:

1. That UW SOD may share any financial information I provide to facilitate payment.
2. To assign UW SOD all insurance benefits payable for services rendered.
3. To pay in full at time of service if I do not have insurance coverage for my care.
4. To pay UW SOD for balances remaining after insurance benefits are paid, unless prohibited by law or contract.
5. To pay any coinsurance or deductibles required by the terms of my insurance benefits.
6. To pay for any services not covered by my dental or medical insurance company.
7. To notify UW SOD of changes to my insurance coverage and/or address.
8. That UW SOD may impose reasonable interest, late charges, costs and/or reasonable attorney's fees should my account become delinquent.
9. That any lawsuit for collection of my account may be brought in King County, Washington.

Patient Name: _____ **Birth date:** _____

SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

I understand that:

1. If UW SOD does not contract with my insurance plan, the UW SOD will process my insurance claim as a courtesy and I am responsible for payment at the time of service.
2. I am responsible for knowing my insurance coverage and benefits. I may request a pre-authorization or predetermination for services from my insurance.
3. If I present a current Washington State Medicaid Provider One Card, benefit eligibility will be verified from the Provider One website at registration. Certain procedures require preauthorization before the onset of care, and in this case, treatment may be delayed until the authorization is received.
4. Medicare covers limited dental procedures and only when related to a medical condition, unless a supplemental dental insurance has been purchased. I am responsible for providing this dental insurance information at the time of registration or service.
5. The UW SOD and other UW entities each bill seperately for services.
6. Certain procedures, such as crowns, inlays, onlays, dentures and bridgework, require an advance deposit. My care provider will inform me of these procedures when discussing my plan of care.
7. If I receive a service that is not covered by my insurance plan or if an insurance claim is unpaid after 8 weeks, I will be responsible for the full cost.
8. Checks returned unpaid by my bank for insufficient funds are subject to a $25 service fee.

Statement to permit payment of Medicare/Medicaid or insurance benefits to provider

I request payment of authorized Medicare/Medicaid benefits for any services furnished to me by UW SOD to be made payable directly to UW SOD. I authorize any holder of medical and other information about me to release to Medicare/Medicaid and its agents or other insurance providers any information needed to determine these benefits or benefits for related services.

Signature

By signing below, I agree to the terms of UW School of Dentistry's Financial Agreement.

SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE

IF SIGNED BY PERSON OTHER THAN PATIENT, CHECK RELATION TO PATIENT:

☐ 1. Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse/Registered Domestic Partner

☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 6. Adult Brother(s)/Sister(s)

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☐ 4. Holder of signed authorization from parent(s) ☐ 5. Adult representing self to be a relative responsible for the minor's health

FOR OFFICE USE ONLY:

(This section below is to be filled out by UW School of Dentistry staff only)

We are unable to obtain acknowledgement from this individual at this time, but immediate treatment is needed for the following reason(s):

Last revised May 15, 2016

Patient Name:_____ **Birth date:**_____

SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Notice of Privacy Practices Acknowledgment

The Notice of Privacy Practices of School of Dentistry brochure describes how your dental and medical information may be used and disclosed, how you can access this information and who to contact if you have questions, concerns or complaints.

We have a responsibility to protect the privacy of your information, provide a Notice of Privacy Practices, and follow the information practices that are described in this notice. If you have any questions, please contact: UW School of Dentistry Patient Relations 206-685-1022.

We may change our policies at any time. Any significant policy change will be posted. You may request a copy of this notice from the UW School of Dentistry Patient Records Office 206-543-7049.

By signing below, I agree that I have received and/or been offered The UW School of Dentistry Clinics and Faculty Practice Notice of Privacy Practices.

SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE

IF SIGNED BY PERSON OTHER THAN PATIENT, CHECK RELATION TO PATIENT:

☐ 1. Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse/Registered Domestic Partner

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Last revised May 15, 2016

Patient Name:_____ **Birth date:**_____