UNIVERSITY OF WASHINGTON

DECOD Website: https://dental.washington.edu/decod/

SCHOOL OF DENTISTRY
DECOD Dental Clinic
PHONE #: (206) 543-4619
FAX #: (206) 221-5276
EMAIL: decod@uw.edu

Dental Education in the Care of Persons with Disabilities

Patient Intake Form

Please mark as applicable:

____ New Patient
____ Returning Patient *(Patient was last seen in DECOD over 3 years ago)*

Name: *Last First Middle*	*Date of Birth*	*Sex*
Address: *Street City State Zip*	*Home Phone*	
Physician - Name, Telephone Number	*Clinic Affiliation*	
Referred by - Name, Address, Telephone Number		
Case Manager *- Name, Telephone Number*		
Guardian *- Name, Address, Telephone Number*	*Email Address*	
Emergency Contact *- Name, Telephone Number*	*Relationship*	
Method of Payment (please attach insurance card) ☐ Apple Health / ProviderOne # _____ ☐ Private Dental Insurance	☐ Self-pay ☐ Other	
I will have a caregiver, family member, or other support person accompany me to the appointment	☐ Yes *Relationship* ☐ No	

Form Completed by: _____ Form Submission Date: _____

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About You

Patient Name: _____ Date of Birth: _____

Care Support

The DECOD clinic recognizes that our patients may require help to receive dental treatment. Some types of support are listed here, along with a brief description. Please indicate with a **checkmark** if you have used in the past or are requesting any of the supports below.

- ***Oral sedation*** is an anti-anxiety medication taken before a dental visit. It is used for patients with mild to moderate dental anxiety.
- ***IV sedation*** is used in patients with moderate dental anxiety. It is only used in patients who allow IV placement in an office setting.
- ***General anesthesia*** or going to sleep is used to perform dental treatment at the hospital. It is used when all other options have failed and the patient cannot have treatment in the dental chair through less invasive adaptations.

In the Past, I	Have used /	Request
Oral Sedation	_____	_____
IV Sedation	_____	_____
General Anesthesia	_____	_____

- Papoose boards may be used to control unsafe body movements during dental care
- Mouth Props may be used to help the patient hold their mouth open during dental care
- Some patients benefit from other supportive techniques

In the Past, I	Have used /	Request
Mouth Prop	_____	_____
Papoose Board	_____	_____

What helps you be more comfortable with dental treatment? _____

Oral Hygiene

Prevention is key to maintaining dental health. Proper oral hygiene is the mainstay in preventing the two most common dental problems: dental decay and gum disease. Here at DECOD, we are committed to providing information to help our patients maintain a healthy mouth. Please tell us a little about your current oral hygiene routine to assist you in this goal.

I brush my teeth

____ YES
____ NO

Someone helps me brush my teeth

____ YES
____ NO

I am interested in information on improving my oral hygiene

____ YES
____ NO

Please list any concerns regarding your oral hygiene _____

_____

_____

_____

_____

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About You *(Optional)*

Patient Name: _____ Date of Birth: _____

Interests / Likes

We would love to learn more about your interests and preferences. We believe sharing what you enjoy will help you feel comfortable at DECOD.

What are your hobbies/interests?

- ☐ ***Arts and Crafts***
- ☐ ***Outdoor activities***
- ☐ ***Time with family/pets***
- ☐ ***Reading/Audio Books***
- ☐ ***Watching TV***
  Type(s): _____
- ☐ ***Video Games***
- ☐ ***Cooking/Baking***
- ☐ ***Other*** _____

What helps you relax during a clinic visit?

- ☐ ***Listening to Music***
  What type of music do you like?
  _____
- ☐ ***Other:*** _____

Religious & Cultural Concerns

If there is anything you would like to share about your religious and/or cultural beliefs that you feel may impact your dental care, feel free to share here:

_____

_____

_____

Employment

We understand many of our patients may have work commitments during clinic hours. If you are currently employed, please provide your job title and indicate whether you prefer to schedule your dental appointment in the morning or afternoon.

NOTE: While we will try to accommodate your preferences, we apologize in advance if we cannot meet your exact scheduling requests.

What is your job?

_____

How often do you work?

- ☐ Part-time
- ☐ Full-time
- ☐ Other: _____

What day works best for you for a dental appointment? Select all that apply:

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday

When are you available?

- ☐ Mornings (9:00 AM-12:00 PM)
- ☐ Afternoons (1:30 PM-4:30 PM)

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Health Questionnaire

Patient Name: _____ Date of Birth: _____

Date Form Filled Out: _____ Height: _____ Weight: _____

Have you had any of the following?

Yes ◯ No ◯ Surgery, serious illness, or hospitalization? Please specify: _____

_____

_____

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/Zoledronic Acid Other _____

Yes ◯ No ◯ ***Other Antiresorptive Bone Medications***

Denosumab/Prolia/Xgeva Other _____

Yes ◯ No ◯ ***Blood thinners?***

Coumadin/Warfarin Plavix/Clopidogrel bisulfate Other _____

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Health Questionnaire

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:* _____

Neurological or Nerve Problems
- ☐ Seizure / 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
- ☐ PTSD
- ☐ ADD / ADHD
- ☐ Schizophrenia
- ☐ Anorexia
- ☐ Bullimia
- ☐ Pica
- ☐ Other _____

Vision, Hearing, Skin Conditions
- ☐ Blind
- ☐ Vision impairment
- ☐ Deaf
- ☐ Hearing loss
- ☐ Psioriasis
- ☐ 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
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hypothyroidism
- ☐ Hormone replacement
- ☐ Other thyroid disorders _____
- ☐ 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 & Cancer
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Deep vein thrombosis
- ☐ Cancer
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple myeloma
- ☐ Other _____

Immune & Infectious
- ☐ Immunocompromised
- ☐ HIV
- ☐ AIDS
- ☐ Hepatitis _____
- ☐ MRSA
- ☐ Cold sores
- ☐ Other _____

Gastrointestinal & Kidney
- ☐ Heartburn/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 _____

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Medications List

Patient Name: _____ Date of Birth: _____

Date Form Filled Out: _____ Height: _____ Weight: _____

Medication List

Drug Name	Dosage	Frequency	Reason Taking

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Communication Information

Patient: _____ **Date of Birth:** _____ **UWSOD ID:** _____

I communicate using verbal or sign language

____ YES, Verbal Language

____ YES, Sign Language

____ NO

Describe any limitations in language usage *(e.g., non-verbal, short sentences):*

_____

I prefer to have an interpreter for conversations with my healthcare provider

____ ALWAYS

____ AS NEEDED

____ NO

Specify primary language: _____

I communicate primarily with non-verbal communication *(e.g., gestures, nodding, pointing, facial expressions)*

____ YES

____ NO

Describe non-verbal communication: _____

I use a communication aid *(e.g., alphabet board, picture board, iPad app)*

____ YES

____ NO

Type of communication aid: _____

Date Form Filled Out: _____ **Form Completed by:** _____

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Health Care Decisions Information

Patient: _____ **Date of Birth:** _____ **UWSOD ID:** _____

I make my own health care decisions

____ YES

____ NO

I have a legal guardian who makes health care decisions for me *(list ALL guardians, if multiple)*

____ YES

____ NO

Name of Guardian: _____

How they are related to me: _____

____ Relative (*specify*) _____

____ Guardianship Agency (*specify*) _____

Guardian Phone Number: _____

I have some other form of support for health care decision making

____ YES

____ NO

Name: _____

How they are related to me: _____

____ Relative (specify) _____

____ Power of Attorney_____

____ Other forms of support* (specify) _____

**Please note that RCW 7.70.065 does not allow employees of caregiving agencies to serve as surrogate decision makers (specifically excludes "the owner, administrator, or employee of a healthcare facility, nursing home, or long-term care facility where the patient resides or receives care; or a person who receives compensation to provide care to the patient")*

Their Phone Number: _____

Date Form Filled Out: _____ **Form Completed by:** _____

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Consent for Routine Dental Treatment

UW School of Dentistry – DECOD Program

Information

Routine dental treatment may include:

- Examinations
- X-rays
- Cleanings and fluoride treatments
- Fillings and sealants
- Dentures and crowns
- Local anesthesia ("numbing" of the teeth and mouth)

Providing treatment in a clinic depends on the patient's ability to tolerate care in an office environment. If limitations arise, your provider may recommend alternative treatment options based on your needs.

Routine dental care **does NOT** include:

- Surgical procedures (e.g., tooth extractions)
- General anesthesia
- Medical immobilization (e.g., use of a papoose board)

Additional consent(s) will be required if these services are necessary. If you have questions about routine dental procedures, you may speak with your provider during an appointment or call the DECOD Clinic.

Consent

- I consent to routine dental treatment for the patient named below.
- If any unexpected problems arise during care, I further consent for the dental provider(s) to manage these conditions as needed.
- I understand 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 can find a safe stopping point before the treatment ends. I must inform my dental provider(s) to withdraw my consent.

_____

Patient's name **(printed)**

_____

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

_____

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

Patient Name: _____ **Date of Birth:** _____

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Care Agreement

This form contains facts you should know about your dental care at UW School of Dentistry (UW SOD). If any part of this form is unclear, you can ask questions about it. Your signature is required at the end of this form acknowledging that you have read it (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-Doctoral Student 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 includes 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 record 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 know 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 read this document and agree to receive healthcare from the UW School of Dentistry.

SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE

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

___ Self ___ Guardian ___ Durable Healthcare Power of Attorney
___ Spouse/Registered Domestic Partner ___ Adult Child(ren) ___ Parent(s)
___ Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

___ Guardian/Legal Custodian ___ Court-authorized person for child in out-of-home placement
___ Parent(s) ___ Holder of signed authorization from parent(s)
___ Adult representing themselves to be a relative responsible for the minor's health

Patient Name: _____ **Date of Birth:** _____

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Financial Agreement

Thank you for choosing University of Washington School of Dentistry (UW SOD) for your dental care. We are committed to providing you with 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 the 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. Please ask your insurance company if you're unsure about your insurance coverage.

Insurance billing

- **Contracted coverage:** The School of Dentistry contracts with several insurance companies. If we are in your plan's networks, our billing office will submit claims to your insurance company for the services you receive from us. You are responsible for paying co-pays or any portion not covered by your insurance at the 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 non-covered treatment, 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 their 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 of all bills is due within 30 days from the 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 the 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 deductible 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. Any lawsuit for collecting my account may be brought in King County, Washington.

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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. Specific 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 during registration or service.
5. The UW SOD and other UW entities each bill separately for services.
6. Specific procedures, such as crowns, inlays, onlays, dentures, and bridgework, require an advance deposit. When discussing my care plan, my care provider will inform me of these procedures.
7. I will be responsible for the full cost if I receive a service not covered by my insurance plan, or if an insurance claim is unpaid after 8 weeks.
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 the 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 required to determine these benefits or benefits for related services.

Signature

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

SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE

PLEASE SELECT RELATIONSHIP TO PATIENT:

___ Self ___ Guardian ___ Durable Healthcare Power of Attorney
___ Spouse/Registered Domestic Partner ___ Adult Child(ren) ___ Parent(s)
___ Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

___ Guardian/Legal Custodian ___ Court-authorized person for child in out-of-home placement
___ Parent(s) ___ Holder of signed authorization from parent(s)
___ Adult representing themselves 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):

Patient Name: _____ **Date of Birth:** _____

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Notice of Privacy Practices Acknowledgement

The Notice of Privacy Practices of the 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 are responsible for protecting your privacy, providing a Notice of Privacy Practices, and following the information practices 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 by The UW School of Dentistry Clinics and Faculty Practice Notice of Privacy Practices.

SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE

PLEASE SELECT RELATIONSHIP TO PATIENT:

___ Self ___ Guardian ___ Durable Healthcare Power of Attorney
___ Spouse/Registered Domestic Partner ___ Adult Child(ren) ___ Parent(s)
___ Adult Brother(s)/Sister(s)

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