IUPUI

SCHOOL OF DENTISTRY

INDIANA UNIVERSITY

Indianapolis

Greetings!

Thank you for considering the Indiana University School of Dentistry Hospital Dentistry (IUSD HD) Clinic as a dental home. Our clinic serves those with intellectual and developmental disabilities and/or medical complexity through the use of compassionate, evidenced-based oral health care. Please read this entire packet carefully as it has been designed to create a smooth entrance process into our clinic. You will find forms that must be filled out and additional documentation that must be provided annually in order to be scheduled for an appointment.

To provide timely and appropriate care, the Hospital Dentistry Team requires the following things:

1. Completion of the Face Sheet, Medical History, Surgeries, Medicines, Allergies, Immunizations, and Social History forms
2. Updated copy of guardianship papers or Medical POA documentation from the Courts
3. Current Insurance Cards

Please fill out each form in full and with the most up-to-date information. Upon receiving the completed packet, the IUSD HD team will review the packet and may ask for follow up information. Once approved, the patient will receive a phone call to have their appointment scheduled.

If you have any questions while filling out the paperwork, please do not hesitate to reach out!

Sincerely,

The Indiana University School of Dentistry Hospital Dentistry Team

Face Sheet

Patient First Name	Patient Middle Name	Patient Last Name
Patient SSN	Patient DOB	Patient Gender
Patient Street Address	Patient City	Patient State
Patient Zip Code	Patient Phone Number	Patient Race

Does the Patient have a Legal Guardian? YES NO

Guardian First Name	Guardian Middle Name	Guardian Last Name
Guardian Street Address	Guardian City	Guardian State
Guardian Zip Code	Guardian Phone Number	Guardian Alt Phone Number

Who should be contacted to schedule the patient for clinic appointments?

First Name	Middle Name	Last Name
Street Address	City	State
Zip Code	Phone Number	Alt Phone Number

Medical History

1. Please list all of the patients known current and previous illnesses

   _____
   _____
   _____
   _____
   _____

2. Does the patient have an intellectual disability?

   Yes (Mild, Moderate, or Severe) No

3. If so, which condition do they have?

Autism Down Syndrome Cerebral Palsy _____

Please list all of the patient's physicians, specialty, address, and phone number.

Name	Specialty	Address	Phone Number

Surgical History

If the patient has had surgery, please list the date, location, and reason for the surgery

Date	Location	Reason

If they have been hospitalized, please list the date, location, and reason

Date	Location	Reason

Medications

Please list the medication, dosage, instructions, and which physician prescribe it

Medication	Dosage	Instructions	Prescribe by

Allergies

1. Does the patient have any of the following common allergies?

   Amoxicillin Other Medications Adhesives Latex Food

Please list all of the Patient's Allergies and what type of reaction below:

Allergen	Reaction

Immunizations

Please list all of the vaccinations that the patient has had. For flu shot, please only include most recent year of flu shot.

Vaccine	Date

Social History

1. Alcohol Use?
    a. Yes No
    b. If yes, please describe amount used: _____
2. Tobacco Use?
    a. Yes No
    b. If yes, please describe amount used: _____
3. Illicit Drug Use?
    a. Yes No
    b. If yes, please describe amount used: _____
4. Please describe to patient current living situation (Lives with Parent/Guardian, Live in Residential Care Facility)

    _____
    _____
    _____
    _____
    _____

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IUSD Hospital Dentistry Clinic Guidelines

1. The patient will always be accompanied by an up-to-date medications list, insurance cards, and basic information to every appointment.
2. Patient will be expected to update paperwork annually, even if there have been no changes.
3. If a caretaker or guardian is accompanying a patient, they will have a thorough understanding of the patient's history and recent updates. This person must have an understanding of who the patient is and CANNOT just be a driver.
4. When transferring your dental home to the IUSD Hospital Dentistry Clinic, please obtain at least the last TWO years of dental records for the patient. This includes Doctor's notes, radiographs, and models if they exist.
5. If the patient has a guardian and they will not be present at the appointment, the guardian MUST:
    a. Have been made aware of the appointment in advance by the CARETAKER
    b. Be available by telephone throughout the duration of the appointment
    c. Understand the purpose of the appointment
6. The patient MUST arrive 15 minutes prior to their appointment time. If it is the first appointment, they must arrive 30 minutes prior to their time
7. Please contact our office (317-274-3311) at least 72 hours prior to the appointment if you must cancel. If the patient cancels within 72 hours or no-shows 3 appointments, the clinic will review the patient's status within the clinic. The patient may be discharged at this point in time.
8. Please contact the clinic at least THREE BUSINESS DAYS prior to needing a medication refill. Please note, medications will not be refilled without a recent appointment within the past 12 months and are at the discretion of the dentist.

Patient/Guardian Signature

_____ Date: _____

Primary Caretaker or Head Nurse if patient live in a care facility

_____ Date: _____

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IUSD Hospital Dentistry SCOPE OF CARE

In order to provide optimal and timely dental treatment, please carefully read the following. If the type of treatment you are seeking is not listed, please consider seeking treatment in another clinic of IUSD or by a private practitioner in the community. This document outlines the treatments that the IUSD Hospital Dentistry Team can provide:

1. Comprehensive Oral Exams, Periodic (6 month, yearly), and Emergent Exams
2. Clearance exams prior to Organ Transplant, Head & Neck Radiation, Cardiac Surgery, Joint Replacement, and other medical procedures
3. Hygiene (regular cleanings, deep cleanings)
4. Fillings
5. Extractions of broken or decayed teeth
6. Basic replacement of missing teeth, including partial and complete dentures ("Plates")

IUSD Hospital Dentistry Team **DOES NOT** provide the following MODALITIES of care:

1. **IV Sedation (in office procedures while asleep)**
2. Oral Medication Sedation by advanced prescription
3. Root Canals
4. Implant Dentistry

Patient/Guardian Signature

_____ Date: _____

Primary Caretaker or Head Nurse if patient live in a care facility

_____ Date: _____