PATIENT WITH DISABILITIES CHECK LIST

Name of patient:_____
Parent/guardian name:_____
Date of birth:_____ Phone number:_____

GENERAL

- Do you have specific dental concerns?_____

  _____

- *We have a form called a "Dental Passport" we would like to have completed for [name]. This is a way for you to share important information our team can use to be better prepared for a successful dental appointment.*
  Where should we send the Dental Passport?

  _____

- Are there any professionals that we should speak to before this appointment regarding [name] special needs?

  _____

INSURANCE

- Does your child have insurance? YES/NO
  - Private:_____
  - KanCare Name of MCO:_____
  - Other payment support:_____
- Your insurance may have extra benefits, such as assistance with transportation or interpreter services. Would any of these be helpful? YES/NO Needed support: _____

SCHEDULING

- Is there a time of day that works best for your child?_____
- Would your child benefit from an office tour and introduction to the dental team before their appointment? YES/NO
- Will your child need consistency with follow-up appointments such as: same dental assistant, same room, etc.? YES/NO

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