



**FEATHERSTONE RIDGE PROGRAM - DENTAL CLINIC  
LOCATED AT THE  
UTAH STATE DEVELOPMENTAL CENTER (USDC)**

**Thank you for your interest in accessing services at the Featherstone Ridge Outpatient Dental Clinic. In order to apply for services, please complete the following steps:**

- Accurately complete all pages of the Request for Services form.
- Obtain and attach historical medical records of the patient.
- Obtain and attach historical dental records of the patient.

When the Request for Services and medical/dental records are received at USDC, a committee will review the request. Upon approval, a visit will be scheduled with USDC medical personnel and the actual dental appointment will be made at this time. You will be given several consent forms to complete, to be signed by the legal guardian and returned prior to the first dental appointment.

During the first dental appointment, the teeth will be cleaned, x-rays will be taken, and an evaluation will be completed, depending upon the cooperation of the client. Some minor dental work may also be performed. The USDC dental staff will make recommendations concerning the extent of dental treatment services that are needed.

If anesthesia is required, you will be given forms to be completed by the client's physician, to be signed by the legal guardian, including two witness signatures. Anesthesia forms must be returned one week prior to the scheduled dental appointment.

If you have further questions, please contact the Featherstone Ridge Dental Clinic Representative at 801-763-4164.

# FEATHERSTONE DENTAL CLINIC REQUEST FOR OUTPATIENT DENTAL SERVICES

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TO AVOID DELAY IN REQUEST, PLEASE RESPOND COMPLETELY TO ALL AREAS  
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**SERVICE REQUEST FOR:**

Name:	Date of Birth:
Social Security #:	Telephone:
Address:	
Has the above individual been determined eligible for services from the Division of Services for People with Disabilities?    Yes <input type="checkbox"/> No <input type="checkbox"/>	
Type of service:	

**PERSON REQUESTING SERVICES IF OTHER THAN ABOVE:**

Name:	Title:
Address:	Telephone:
Relationship to patient (DSPD regional staff, QIDP, other):	
When is the best time to contact you?	
Additional contact (Support Coordinator, QIDP, etc.):	
Telephone:	
Legal Guardian:	
Address:	Telephone:

**INSURANCE INFORMATION:**

Name of Insurance Company(ies):	
ID#:	
Policy Holder:	
Medicaid #:	Medicare #:
Who will pay for services not covered by insurance?	
Billing Address:	Telephone:

## MEDICAL HISTORY FORM

**\*\*\*MEDICAL AND DENTAL RECORDS MUST ACCOMPANY THIS FORM\*\*\***

*For your safety please answer all questions carefully and honestly*

	Yes	No
1. Have you ever been a patient at USDC?		
2. Are you taking or have you ever taken blood thinners, Coumadin, prednisone, heart pills, steroids, nerve pills, blood pressure pills, Fen Phen (diet pills) or Insulin? (circle which)		
3. Do you use herbal or food supplements? If yes, please list		
4. List any medications you are now taking or have taken in the past four months (Females – Are you taking a birth control pill? There is a higher incidence of "Dry Socket" with that medication. Also, if antibiotics are prescribed, the effectiveness of a birth control pill may be reduced and a pregnancy may occur) :		
5. Are you allergic to, or have had an unfavorable reaction to any medication?		
6. Do you itch, wheeze or get a rash from latex or a rubber product?		
7. Have you had an unfavorable reaction to local (numbing) or general (asleep) anesthetics?		
8. Do you use recreational drugs – i.e. : L.S.D., "Speed", "Downers", Mescaline, Cocaine, others?		
9. Have you ever been hospitalized or operated on? List year and reason:		
10. Have you had an unfavorable reaction from previous dental treatment?		
11. Do you get infections, sores, boils, sore throat or respiratory problems easily?		
12. Have you ever had Radiation Therapy for tumors?		
13. Have you or any family member had problems breathing following an anesthetic?		
14. Have you had recent weight changes or history of fever or chills and excessive sweating?		
15. What is your current Height? <span style="float: right;">Weight?</span>		
16. Do you get frequent headaches?		
17. Do you wear glasses, contact lenses, see double, or have glaucoma? (circle which)		
18. Do you have/had hearing difficulties, ringing in your ears, dizziness, earaches, drainage from ears, sinusitis, frequent nose bleeds, difficulty breathing through your nose? (circle which)		
19. Do you have/had breathing problems such as asthma, wheezing, T.B., chronic cough, coughed up blood, coughing spells, excessive sweating, emphysema? (circle which)		
20. Do you smoke? <span style="float: right;">Packs per day? <span style="float: right;">Use Alcohol?</span></span>		
21. Do you have/had heart trouble, angina, chest pain, shortness of breath while laying flat or while climbing stairs; irregular pulse, palpitation, high blood pressure, heart murmur, rheumatic fever, dizziness, or fainting when getting up suddenly, ankle swelling, stroke? (circle one)		
22. Do you have/had stomach or liver problems, ulcer, vomited blood, colitis, yellow jaundice, hepatitis, frequent constipation? (circle which)		
23. Do you have/had kidney problems, frequent urination, frequent night time urination, nephritis, difficulty urinating, burning, blood in urine? (circle which)		
24. (Women) – Are you pregnant? <span style="float: right;">Month?</span> Number of past pregnancies: <span style="float: right;">Are you nursing at present?</span>		
25. Do you have/had thyroid trouble, fast heart rate, hot or cold intolerance? (circle which)		
26. Do you have diabetes, hypo-glycaemia, chronic thirst? (circle which)		
27. Do you have/had rheumatoid arthritis, broken bones, muscular dystrophy, polio (circle which)		
28. Does/has your jaw popped, clicked, cracked or locked open or shut (circle which)		
29. Have you been diagnosed with HIV, AIDS or ARC (auto-immune disorders)?		
30. Do you have/had anemia, bleeding problems, bruise easily, hemophilia? (circle which)		
31. Do you have/had fainting spells, convulsions, epilepsy, use Dilantin, subject to nervous disorder?		
32. Do you have Anorexia or Bulimia?		

Please check the boxes below:

- I have reviewed the above, and it is current and accurate.
- I have attached complete medical and dental historical records

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient, Parent, Guardian (circle)