盈愛 無障牙科中心
Loving Smiles
Special Care Dental Centre

Healthy Teeth Collaboration

Application and Assessment Form

Personal Particulars of Applicant (Please put a '✓' in the appropriate boxes ☐)

Patient No: _____ HTC Registration No.: _____

Name in Chinese: _____ Name in English: _____

Applicant's Abilities:

Intellectual disability:	☐Mild	☐Moderate	☐Severe	☐Profound	☐Autism Spectrum Disorder
Physical mobility:	☐Nil	☐Mild	☐Wheelchair user	☐Wheelchair bound	☐Other:_____
Communication status:	☐Nil	☐Vision impairment	☐Hearing impairment	☐Speech impairment	☐Other:_____
Mental status:	☐Nil	☐Autism	☐ADHD	☐Mental illness	☐Other:_____
Situation when anxiety arises:	☐Nil	☐Sensitive to light	☐Sensitive to noise	☐Sensitive to touch	
		☐Sensitive to movement of dental chair		☐Other:_____	

Applicant's Health Status:	Body weight: kg	Height: cm	BMI:

Conditions:	Yes	No
1. Have ever received general anesthesia?	☐	☐
2. Any problem occurred during past surgery or general anesthesia?	☐	☐
3. Are there any adverse reactions to general anesthesia amongst applicant's relatives	☐	☐
4. Had been hospitalized?	☐	☐
5. Need to take any medicine? (If yes, please attach medication records)	☐	☐
6. Any allergic reactions to some food, medicine or other thing? (If yes, please specify:)	☐	☐

Applicant's Medical Conditions (*Please select the appropriate):

Medical Condition	Yes	No	Medical Condition	Yes	No
a. Need 2-3 pillows when sleeping for better breathing	☐	☐	n. Diabetes	☐	☐
b. Snore while sleeping	☐	☐	o. Other endocrine disease (e.g. adrenal disease)	☐	☐
c. Pant when walking 2 flights of stairs	☐	☐	p. Swallowing difficulty / Tube feeding / Gastroesophageal reflux / Stomach disease*	☐	☐
d. Chest pain / angina during walking or mild exercise*	☐	☐	q. Kidney / Bladder disease*	☐	☐
e. Ankle swelling	☐	☐	r. Stroke	☐	☐
f. Sleep apnea	☐	☐	s. Epilepsy (Seizure)	☐	☐
g. Asthma / Bronchitis / Emphysema*	☐	☐	t. Muscular dystrophy	☐	☐
h. Tuberculosis	☐	☐	u. Scoliosis / Arthritis / Osteoporosis*	☐	☐
i. Other lung disease (e.g. pulmonary fibrosis)	☐	☐	v. Anaemia / Thalassemia*	☐	☐
j. Hypertension	☐	☐	w. Bleeding tendency (e.g.Haemophilia / platelet disorder*)	☐	☐
k. Coronary heart disease	☐	☐	x. Infectious disease (AIDS / HIV / Hepatitis*)	☐	☐
l. Heart murmur / Arrhythmia*	☐	☐	y. Jaundice / Liver disease*	☐	☐
m. Thyroid disease	☐	☐	z. Genetic diseases (e.g. Down's, G6PD*)	☐	☐
If there is other medical condition, please specify:					

Applicant's Dental Conditions:

When was the last dental consultation?	☐___ month(s) ago	☐___year(s) ago	
What was the last dental treatment?	☐Checkup	☐Professional teeth cleaning	☐Fillings
	☐Extractions	☐Pulp treatment	☐Denture
How cooperative was the last visit to the dentist?	☐Lying cooperatively on dental chair	☐ Guided by accompanied person	☐Refused to lie on dental chair
	☐Required physical restrain	☐Needed general anesthesia	
How emotional was the last visit?	☐Stable	☐Resistive	☐Fearful
	☐Irritable	☐Destructive	☐Violent
Who looks after applicant's oral care?	☐Himself/herself	☐Family members	☐Domestic helper
	☐Staff of residential home		
Any smoking habit?	☐Yes, daily smoker	☐Yes, occasional smoker	☐No
How many tooth brushing times per day?	☐Once in the morning	☐Once in the afternoon	☐Once at night
	☐No brushing (reluctant)	☐No brushing (no teeth)	
What type of toothbrush used?	☐Manual toothbrush	☐Electric toothbrush	
Any oral care aid(s) used?	☐Nil ☐Interdental brush	☐Single tuft toothbrush	☐Floss stick
	☐Dental Floss ☐Normal saline	☐Mouth rinse (brand)	
What toothpaste is used?	☐Fluoride-containing toothpaste		☐Others ( )
What type of everyday meal?	☐Ordinary meal	☐Minced meal	☐Soft meal
	☐Mushy meal	☐Nasogastric tube feeding	☐Others ( )
Any dysphagia (swallowing difficulty)?	☐Always ☐Occasional	☐Seldom	☐No
Wearing dentures?	☐Yes (denture type: ☐fixed / ☐removable)		☐No
Any current dental problems?	☐Bleeding on tooth brushing	☐Calculus	☐Gingival inflammation
	☐Tooth decay	☐Mobile teeth	
	☐Other ( )		☐Unknown

The information about the Applicant in this form is provided to the best of my knowledge.

Name of Applicant/ Family Member/Guardian/: _____
Representative of Service Unit

Relationship with Applicant (if any)/_____
Name of Service Unit

Signature/Chop of Service Unit: _____

Date: _____

Consent for dental treatment and Clinical photo taking

(For Applicant/Family Member/Guardian)

I (Name) _____agree to the provision of dental treatment including treatment under sedation by the dentists of Loving Smiles Foundation Limited to the applicant (Name) _____. I also consent to the taking, storage and use of clinical photographs of the applicant for medical/dental records and for application for subsidy for the applicant's treatment.

Relation with the Applicant: *Applicant/Family Member/Guardian

Contact Tel No./WhatsApp: _____

Signature: _____

Date: _____

* Delete where inappropriate

(Without Legal Guardian)

No legal guardian has been identified for the applicant. Treatments that are necessary and of the best interest of the applicant will be provided under professional judgement.

Name of Dentist: _____ Signature: _____ Date: _____

Statement on personal data collection

1. All the personal data are provided on voluntary basis. They will be used by the Loving Smiles Foundation Limited for the purposes of provision of dental service, and oral health evaluation and data analysis.
2. The personal data provided are mainly for use within the dental clinics operated by the Loving Smiles Foundation Limited. The personal data will be disclosed to the Department of Health. Otherwise, they may only be disclosed to parties where you have given consent to such disclosure or where such disclosure is allowed under the Personal Data (Privacy) Ordinance.
3. You have the right to access and correction with respect to your personal data as provided for in Sections 18 and 22 and Principle 6 of Schedule 1 of the Personal Data (Privacy) Ordinance.
4. Enquiries concerning the personal data provided, including the making of access and corrections, should be addressed to: Loving Smiles Foundation Limited, Shops E13-15, G/F, Cho Yiu Centre, Cho Yiu Chuen, Kwai Chung, N.T.

Please complete the Application and Assessment form and fax to 2370 0319 together with the medication records, if any.
For enquiries, please call 2370 2669.