

Department of Health and Wellness  
**INDIVIDUALS WITH SPECIAL NEEDS ORAL HEALTH PROGRAM (SNP)**  
**REGISTRATION FORM**

<b>PATIENT INFORMATION</b>
<p>Patient's Full Name: _____</p> <p>MSI Health Card #: _____ Date of Birth: _____</p>
<b>PHYSICIAN'S STATEMENT (PROVIDE COMPLETE DETAILS OF MEDICAL DIAGNOSIS INCLUDING THE ICD CODE(S))</b>
<p>_____</p> <p>_____</p> <p>ICD code(s): _____ Chair management untenable: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>This is to confirm that the above patient has an intellectual disability to the degree that chair management for dental services is untenable.</p> <p>Physician's Name: _____ Physician's Signature: _____</p> <p>Date: _____</p>
<b>DENTIST'S STATEMENT</b>
<p>Due to the medical condition of this patient as verified by this form, which has been signed by Dr. _____, M.D., the proposed dental treatment can be performed in office or in hospital setting.</p> <p>Dentist's Name: _____ Dentist's Signature: _____</p> <p>Date: _____ Fax #: _____ Email: _____</p>
<b>GSC/DHW Use Only</b>
<p>Registration Confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments: _____</p> <p>_____</p> <p>Signature: _____ Date of request: _____</p>

## SUBMISSION INFORMATION

Submit the form to GreenShield Canada by either Provider Connect with an attached file to the NS Government mailbox online <https://www.providerconnect.ca/Forms/Attachments/ProviderAttachments> or by manual submission via postal mail to:

**GreenShield Canada**

**Attn: Dental Services Dept – Individuals with Special Needs Oral Health Program Registration**

**P.O. Box 1671**

**Windsor, Ontario N9A 0C6**

Only complete applications will be considered.

**Note:** Both Physician and Dentist statement including ICD code must be indicated on form.