FLORIDA SPECIAL CARE DENTISTRY

Today's Date: ___/___/_____

Patient's Name: _____ Sex: ❑ Male ❑ Female Age: _____

Date of Birth: _____ Relationship: _____ Patient's SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

In case of an emergency who should we contact?

Name: _____ Phone #: _____ Relation: _____

Insurance Information:

Name of Card Holder: _____ DOB: _____ SS#: _____

Name of Insurance: _____ Policy #: _____

Your Doctor's Information:

Referring Dentist's Name: _____ Phone #: _____

Physician's Name: _____ Phone #: _____ Fax #: _____

Cardiologist's Name: _____ Phone #: _____ Fax #: _____

.....

Reason for visit here: _____

_____

_____

Do you have any family members who have been patients here: Yes or No

If yes, list name: _____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam? _____
4. Are you now under a physician's care for ..... Y N particular problem?
   If so, what for? .....
5. Have you had any serious illnesses, operations or hospitalizations?
   If so, describe: _____
6. Have you had any adverse effects from anesthesia ..... Y N
7. Do you have or have you ever had:
   - A. Rheumatic fever or rheumatic heart disease? ..... Y N
   - B. Congenital heart disease? ..... Y N
   - C. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery. pacemaker)? ..... Y N
   - D. Lung disease (asthma, emphysema, chronic cough, Bronchitis, pneumonia, tuberculosis, shortness of Breath, chest pain, severe coughing)? ..... Y N
   - E. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown? ..... Y N
   - F. Bleeding disorder, anemia, bleeding tendency, blood Transfusion, do you bruise easily? ..... Y N
   - G. Liver disease (jaundice, hepatitis)? ..... Y N
   - H. Kidney disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid disease (goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach ulcers or colitis? ..... Y N
   - M. CHF congestive heart failure ..... Y N
   - N. COPD chronic obstructive pulmonary disease ..... Y N
   - O. Implants placed anywhere in your body (Heart valve, hip, knee)? ..... Y N
   - P. Radiation (x-ray) treatment for cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - R. Sinus or nasal problems? ..... Y N
   - S. Any disease, hiv, or transplant operation that has Depressed your immune system ..... Y N
   - T. Recurrent infections of any kind? ..... Y N
   - U. (Please circle one)
     - Delayed development ..... Y N
     - Mental retardation ..... Y N
     - Autism ..... Y N
     - Cerebral Palsy. ..... Y N
     - Down syndrome. ..... Y N
     - Other ..... Y N
   - V. Cleft lip, cleft palate, craniofacial anomaly. ..... Y N
8. Are you using or taking any of the following:
   - A. Tagamet? ..... Y N
   - B. Thyroid medications? ..... Y N
   - C. Antibiotics or sulfa drugs? ..... Y N
   - D. Anticoagulants (blood thinners)? ..... Y N
   - E. High blood pressure ..... Y N
   - F. Steroids (cortisone, etc)? ..... Y N
   - G. Tranquilizers (valium, etc.)? ..... Y N
   - H. Insulin, diabetes, or similar drug? ..... Y N
   - I. Digitalis, inderal, nitroglycerin, calcium channel Blockers, procardia or other heart medicine? ..... Y N
   - J. Aspirin or ibuprofen (motrin, naprosyn, etc)? How much daily? _____ ..... Y N
   - K. Marijuana or other "street" drugs? ..... Y N
   - L. Antihistamines or decongestants (seldane)? ..... Y N
   - M. Fosamax, aredra, zometa or bisphosphonates ? ..... Y N
   - N. Are you taking any other regular medications, pills, Or drugs? ..... Y N

     If yes, please list: _____
9. Are you allergic or had bad reaction to:
   - A. Local anesthetic (novocaine, etc.)? ..... Y N
   - B. Penicillin, amoxicillin, cephalosporins or other antibiotics ..... Y N
   - C barbiturates, sedatives, etc.? ..... Y N
   - D. Aspirin or ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or rubber products? ..... Y N
   - G. Other allergies or reactions? ..... Y N

     If yes, please list: .....
10. Do you smoke or chew tobacco? ..... Y N

    How much daily: _____
11. Do you use alcohol? ..... Y N

    How much? _____
12. Have you ever sought professional care for drug abuse, Alcoholism or emotional disorders? ..... Y N
13. Women: are you pregnant or planning pregnancy? ..... Y N
    are you taking birth control pills? ..... Y N
    are you taking hormone replacements? ..... Y N
14. Do you have any other disease, condition or problem not Listed above that you think the doctor should know About? ..... Y N
15. Do you wish to talk with the doctor privately about Anything? ..... Y N

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.

_____ _____

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY / RELATIONSHIP | DOCTOR'S INITIALS

Florida Special Care Dentistry
One Davis Blvd, Suite 103 Tampa, Fl 33606
OFFICE POLICY
General Consent / HIPAA

Appointments: Due to the high volume of patients, and in respect to the practice and to our other scheduled patients, we do require confirmation of appointments and prompt attendance. For your convenience we have a text-confirming system which you can confirm appointments by responding to text notification. If this is not available with your phone, a courtesy call will be made to you. Response is required with all confirming, non-response does NOT cancel your appointment and non appearance may result in broken appointment fees. If you need to make any changes or appointment cancellations, a 2-business day notice is required to avoid broken appointment fees.

_____ By initialing this I understand and agree to the above information.

Authorization: I hereby authorize Dr Powless and his professional dental team to proceed with and perform all general procedures including but not limited to Radiology, Intra Oral photo, examinations, Hygiene procedures, and restorative procedures. I understand treatment will be presented and fully explained to me prior to procedures. I further understand there are guidelines that are required by law to uphold in relation to yearly exams and x-rays that the practice does have to follow. I understand that dentistry is not an exact science, with consideration of 2 dimensional x-rays of 3 dimensional teeth and there can be unforeseen circumstances that may arise and cause modifications of treatment which reputable practitioners cannot properly guarantee results of. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have authorized.

_____ By initialing this I understand and agree to the above information.

Financial:

In consideration of the professional services rendered to me by this practice, I understand payment is due at time of service and agree to make full payment. Any exception to this would have to be pre arranged with a signed written agreement. I understand if any payment agreement is not upheld with payments made on time, that any discount extended in the agreement will be null and void and full treatment fees will be reinstated and due by patient/guarantor.

As a courtesy to our insured patients we will file claim for payment, however ultimately the patient is responsible to know their policy and clauses and is responsible for the account to be paid in full. Insurances are required to pay within 30 days of claim filed, if payment is not received by insurance within that time frame, the balance will then be due from the patient/guarantor.

_____ By initialing this I understand and agree to the above information.

HIPAA: I understand I can refuse to sign the HIPAA Privacy Act.

I acknowledge and understand that a copy of the Privacy Act is available to me upon request. I understand private information will not be given out without my consent; however I do agree to allow information to be released to insurance companies for payment if applicable. I understand I can list any person(s) of which the practice, Dr and Staff have my permission to discuss my treatment with.

_____

_____ By initialing this I understand and agree to the above information.

I understand and am in agreement with all of the above.

_____ / _____ _____

Patient/guarantor Signature Printed Date

_____ / _____ _____

Witness Signature Printed Date