Welcome
to
Florida Special Care Dentistry

We would like to welcome you and your child to our office. Our goal is to make every child's visit **pleasant and educational.** Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have **a beautiful smile that lasts a lifetime.**

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ABOUT YOUR CHILD

Name: _____
LAST FIRST MI

Nickname: _____

Birthdate: _____ ❑ Male ❑ Female

Social Security #: _____

Special Interests, Sports or Hobbies: _____

_____

Siblings: _____

Home Address: _____

_____
APT/CONDO # CITY STATE ZIP

Home Phone: _____

Referred By: _____

2

ABOUT YOU

Your Name: _____

Relationship to Child: _____

Your home phone and address, if different from your child's

Home Phone: _____

Address: _____

_____

Occupation: _____

Employer: _____

Work Phone: _____ Ext. _____

Beeper/Cell Phone: _____

email: _____

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DENTAL INSURANCE COMPANY

Dental Ins. Co: _____

Insurance Company Phone: _____

Group #: _____

This Dental Insurance is provided through:

Insured's Name: _____

Insured's Social Security #: _____

Relationship to Child: _____

Insured's Birthdate: _____

Insured's Employer: _____

FOR OFFICE USE ONLY

Deduct _____ P. Deduct _____ Max _____

Preventive _____ % - Frequency _____

Basic _____ %

Major _____ %

Seal _____ % to age _____ on _____

Ortho _____ % Max _____ Ded _____

Comments: _____

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MEDICAL HISTORY

Has your child ever had any one of the following conditions? Please circle.

Y	N	Anemia	Y	N	Pregnant
Y	N	Asthma, Lung Problems	Y	N	Herpes
Y	N	Bleeding Problems	Y	N	Kidney Disease
Y	N	Blood Pressure Problems	Y	N	Rheumatic Fever
Y	N	Cerebral Palsy	Y	N	Liver Disease, Hepatitis
Y	N	Cleft Lip/Palate	Y	N	Malignancy, Cancer
Y	N	Delayed Development	Y	N	Mental Retardation
Y	N	Diabetes	Y	N	Heart Condition, Murmur
Y	N	Ear Infections	Y	N	Psychiatric Problems
Y	N	Emotional Disturbance	Y	N	Immunologic Disorder, HIV
Y	N	Fainting Spells	Y	N	Seizures, Epilepsy
Y	N	Hearing Loss, Impairment	Y	N	Sickle Cell Anemia
Y	N	Autism	Y	N	Down Syndrome

Is your child ALLERGIC or has your child had an ADVERSE REACTION to any medication? _____Y ____N

If yes, please list: _____

Please list any medications your child is currently taking: _____

_____

Any problems not listed above? _____

Has your child ever had any serious illnesses, operations, or hospitalization? _____Y ____N

Has your child had any adverse effects from anesthesia? ____Y ____N

Child's Physician: _____

Last Exam: _____

Up to date on immunizations/boosters? _____Y ____N

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DENTAL HISTORY

Is this your child's first visit to the dentist? _____

If no, what is the approximate date of last visit? _____

Is your child's home supplied with well water or city water? _____

Does your child receive fluoride tablets, drops, vitamins, or rinse? _____

Does your child brush his or her teeth daily? _____

Do you assist them? _____

Does your child suck his or her thumb or finger or have any similar habits? _____

At what age was bottle or breast feeding stopped? _____

Has your child ever had orthodontic treatment? _____

Has your child complained about pain, swelling, or other problems? ____

Are you and your child happy with his/her facial appearance? _____

Appearance of their teeth? _____

Would you predict your child's behavior to be:

❑ Cooperative ❑ Fearful ❑ Defiant ❑ Don't Know

What are your concerns about your child's oral health? _____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. Your child is a minor, therefore it is necessary that a signed permission be obtained from a parent or guardian before necessary dental services can be started. I grant Florida Special Care Dentistry and staff to provide my child's oral examination and necessary treatment. All necessary treatment will be explained prior to commencement. When treatment requires local anesthesia, we usually use nitrous oxide (laughing gas) to relax the patient and make treatment more pleasant.

Parent/Guardian _____ Date _____

The parent or guardian who accompanies the chile is responsible for payment at time of service unless prior arrangements have been approved. I have read and understand the Office Financial Policies.

Parent/Guardian _____ Date _____

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time.

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