Welcome to

FLORIDA SPECIAL CARE DENTISTRY

Please Complete the following to the best of your knowledge, answering each section.

1 – ABOUT YOUR CHILD

Name: _____

Nickname: _____

Birthdate _____/_____/_____ Male Female

Social Sec #_____-_____-_____

Special interests, Sports or Hobbies: _____

_____

Siblings:_____

Address:_____

City: _____ ST:_____ Zip:_____

Home Phone: _____

Referred by: _____

2 – ABOUT YOU- Guardian/Parent

Name: _____

Relationship to child: _____

Your Phone and address, if different from child's:

Address:_____

City: _____ ST:_____ Zip:_____

Home Phone: _____

Cell Phone: _____

Employer: _____

Work Ph: _____ Ext_____

Email:_____

Office Policies:

Please read and initial each section.

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. If you need to make any changes or appointment cancellations, **a 2-business day notice is required to avoid broken appointment fees. _____**

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. 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.

Authorization: I hereby authorize Dr. Powless, Dr. Matos and the dental professional 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 acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have authorized. _____

HIPAA: 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 share my treatment with _____.

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

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

_____ _____ _____

Parent/Guardian Signature Date Witness Signature

Child Name:_____

4 – MEDICAL & DENTAL HISTORY

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

Please circle

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

Is your child ALLERGIC or has your child had an ADVERSE REATION 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)
If yes, explain _____

Has your child had any adverse effects from anesthesia? (Y) (N)

Child's Physician: _____
Phone: _____
Up to date on immunizations? (Y) (N)
Does child see any specialists? _____

Is this your child's 1st visit to dentist? _____
*If no, what is the approximate date of last visit?*_____

Does your child brush his/her teeth daily?_____
How you assist them? _____
Does child suck thumb or similar habits? _____
Has your child have orthodontic treatment?_____
Does child have any dental pain or problems?_____
If yes, please explain: _____

How 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. 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 required local anesthesia, we usually use nitrous oxide (laughing gas) to relax the patient and make treatment more pleasant.

_____ _____ _____
Parent/Guardian Signature Date Witness Signature