

**Florida Special Care Dentistry**  
**R. Andrew Powless, DMD & Jose Matos, DDS**

Today's Date: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: (Male) (Female) Relationship: (Married) (Single) (Child) Patient's SS #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_ Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Guardian: \_\_\_\_\_ (Rel.): \_\_\_\_\_ (dob): \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Do you have any family members who are patients here? (Yes) (No) *If yes, list name(s):* \_\_\_\_\_

**In case of emergency, who should we contact?**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relation: \_\_\_\_\_

Insurance Information: *Please provide any dental insurance information and insurance card upon completion.*

**Your Doctors' Information:**

Primary Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**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. SIGNATURE \_\_\_\_\_

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

\_\_\_\_\_  
Patient or Guardian signature

\_\_\_\_\_  
date

\_\_\_\_\_  
Witness

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

**for Yes on category with multiple answers- please circle which applies.**

1. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? Y N  
 - DATE OF LAST PHYSICAL EXAM \_\_\_\_\_
2. ARE YOU NOW UNDER A PHYSICIAN'S CARE FOR A PARTICULAR PROBLEM? Y N  
 - IF SO, WHAT FOR? \_\_\_\_\_
3. HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS OR HOSPITALIZATIONS? Y N
4. **DO YOU HAVE OR HAVE YOU EVER HAD:**
  - RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE? Y N
  - CONGENITAL HEART DISEASE? Y N
  - **CARDIOVASCULAR DISEASE** (HEART TROUBLE, HEART ATTACK, HEART MURMUR, CORONARY ARTERY DISEASE, ANGINA, HIGH BLOOD PRESSURE, STROKE, PALPITATIONS, HEART SURGERY, PACEMAKER)? Y N
  - **LUNG DISEASE** (ASTHMA, EMPHYSEMA, CHRONIC COUGH, BRONCHITIS, PNEUMONIA, TUBERCULOSIS, SHORTNESS OF BREATH, CHEST PAIN, SEVERE COUGHING)? Y N
  - SEIZURES, CONVULSIONS, EPILEPSY, FAINTING Y N
  - PSYCHIATRIC TREATMENT, NERVOUS DISORDER, BIPOLAR, OR DEPRESSION? Y N
  - BLEEDING DISORDER, ANEMIA, BLEEDING TENDENCY BLOOD TRANSFUSION, BRUISE EASILY? Y N
  - LIVER DISEASE (JAUNDICE, HEPATITIS)? Y N
  - KIDNEY DISEASE? Y N
  - DIABETES? Y N
  - THYROID DISEASE? HYPER/HYPO Y N
  - ARTHRITIS? Y N
  - STOMACH ULCERS OR COLITIS? Y N
  - CHF – CONGESTIVE HEART FAILURE? Y N
  - COPD – CHRONIC OBSTRUCTIVE PULMONARY DISEASE? Y N
  - IMPLANTS PLACED ANYWHERE IN YOUR BODY (HEART VALVE, HIP, KNEE)? Y N
  - RADIATION (X-RAY) TREATMENT FOR CANCER? Y N
  - CLICKING OR POPPING OF JAW JOINT PAIN NEAR EAR, DIFFICULTY OPENING MOUTH, GRIND OR CLENCH TEETH? Y N
  - SINUS OR NASAL PROBLEMS? Y N
  - ANY DISEASE, HIV OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM? Y N
  - RECURRENT INFECTIONS OF ANY KIND? Y N
  - DELAYED DEVELOPMENT? Y N
  - INTELLECTUAL DISABILITY? Y N
  - AUTISM? Y N
  - CEREBRAL PALSY? Y N
  - DOWN SYNDROME? Y N
  - OTHER, NOT LISTED? \_\_\_\_\_ Y N

**ARE YOU USING OR TAKING ANY OF THE FOLLOWING?**

- TAGAMET? Y N
- THYROID MEDICATIONS? Y N
- ANTIBIOTICS OR SULFA DRUGS? Y N
- ANTICOAGULANTS (BLOOD THINNERS)? Y N
- HIGH BLOOD PRESSURE? Y N
- STEROIDS (CORTISONE, ETC.)? Y N
- TRANQUILIZERS (VALIUM, ETC.)? Y N
- INSULIN, DIABETES OR SIMILAR DRUG? Y N
- DIGITALIS, INDERAL, NITROGLYCERIN, CALCIUM CHANNEL BLOCKERS, PROCARDIA OR OTHER HEART MEDICINE? Y N
- ASPIRIN OR IBUPROFEN (MOTRIN, NAPROSYN)? Y N
- MARIJUANA OR OTHER "STREET" DRUGS? Y N
- ANTIHISTAMINES OR DECONGESTANTS? Y N
- FOSOMAX, AREDRA, ZOMETA OR BISPHOSPHONATES? Y N
- **ARE YOU TAKING ANY OTHER REGULAR MEDICATIONS, PILLS OR DRUGS?** Y N

IF YES, PLEASE LIST: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**5. ARE YOU ALLERGIC OR HAD A BAD REACTION TO:**

- LOCAL ANESTHETIC (NOVOCAINE, ETC.)? Y N
- PENICILLIN, AMOXICILLIN, CEPHALOSPORINS, OR OTHER ANTIBIOTICS? Y N
- BARBITURATES, SEDATIVE, ETC.? Y N
- ASPIRIN OR IBUPROFEN? Y N
- CODEINE OR OTHER PAIN KILLERS? Y N
- LATEX OR RUBBER PRODUCTS? Y N
- OTHER ALLERGIES OR REACTIONS? Y N

IF YES, PLEASE LIST \_\_\_\_\_

\_\_\_\_\_

6. DO YOU SMOKE OR CHEW TOBACCO? Y N
7. DO YOU USE ALCOHOL? Y N
8. HAVE YOU EVER SOUGHT PROFESSIONAL CARE FOR DRUG ABUSE, ALCOHOLISM OR EMOTIONAL DISORDERS? Y N
9. WOMEN: ARE YOU PREGNANT OR PLANNING PREGNANCY? Y N  
 ARE YOU TAKING BIRTH CONTROL PILLS? Y N  
 ARE YOU TAKING HORMONE REPLACEMENTS? Y N

DO YOU HAVE ANY OTHER DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT?

\_\_\_\_\_

DO YOU WISH TO TALK WITH THE DOCTOR PRIVATELY ABOUT ANYTHING?

\_\_\_\_\_

**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.**

Print Name \_\_\_\_\_

Signature of patient/guardian \_\_\_\_\_

Date \_\_\_\_\_

Dr's Initials \_\_\_\_\_

For Annual Update: Date: \_\_\_\_\_ Signature: \_\_\_\_\_