St. Pete Family & Cosmetic Dentistry

R. Andrew Powless, DMD & Jose F. 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.*

Primary Physician's Name: _____________________________ Phone: _________________ Fax: ________________

Specialist Physician Name: _____________________________ Phone: _________________ Fax: ________________

Pharmacy Name: _________________________ Phone: _________________ Location: _______________________

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 and his 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.

_________________________________ _________________________ ______________________

Patient or Guardian signature date Witness

**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
   - *Date of last physical exam* ___________________
3. Are you now under a physician's care for a particular problem? Y N
   - *If so, what for?*___________________________
4. Have you had any serious illnesses, operations or hospitalizations? Y N
5. Have you had any adverse effects from Anesthesia? Y N
6. Do you have or have you ever had:
   - Arthritis? Y N
   - Bleeding disorder or Anemia? Y N
   - History of Blood Transfusion? Y N
   - Heart Attack? Y N
   - Heart Murmur? Y N
   - Stroke? Y N
   - Heart surgery or Pacemaker? Y N
   - High Blood Pressure? Y N
   - Cancer? Y N
   - CHF – Congestive Heart Failure? Y N
   - Jaw joint pain/clicking? Y N
   - COPD Y N
   - Diabetes? Y N
   - Implants placed anywhere in your body (Heart valve, Hip, Knee,etc)? Y N
   - Kidney disease? Y N
   - Liver disease (Jaundice, Hepatitis)? Y N
   - Lung Disease (Asthma, Emphysema) Y N
   - Radiation treatment for cancer? Y N
   - Rheumatic Fever or Rheumatic Heart Disease? Y N
   - Seizures, Convulsions, Epilepsy, Fainting? Y N
   - Anxiety or Nervous disorders? Y N
   - Sinus or nasal problems? Y N
   - Stomach ulcers or Colitis? Y N
   - Thyroid disease (Goiter)? Y N
   - Any disease, HIV or transplant operation that has depressed your immune system? Y N
   - Recurrent infections of any kind? Y N
   - Intellectual Disability? Y N
   - **Other condition?** Y N
     If yes please list:_______________________________
7. **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:*__________________________________
     ____
     ____
8. **Are you allergic or had a bad reaction to**:
   - Aspirin or Ibuprofen? Y N
   - Barbiturates, Sedative, etc.? Y N
   - Codeine or other pain killers? Y N
   - Latex or rubber products? Y N
   - Local Anesthetic (Novocaine, etc.)? Y N
   - Penicillin, Amoxicillin, Cephalosporins, or other antibiotics? Y N
   - Other allergies or reactions? Y N
     *If yes, please list*___________________________________
9. Do you smoke or chew tobacco? Y N
10. Do you use alcohol? Y N
11. Have you ever sought professional care for drug abuse, alcoholism or emotional disorders? Y N
12. <u>Women</u>: 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?

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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