Patient Name: ________________________ Date: __________________

Offsite Health History

Patient History

General Questions

Chief Complaint: ______________________________

How long have you had this condition? ______________________________

How would you rate your health? Excellent Good Fair Poor

Are you under the care of a physician? Yes No

If Yes, Dr. ______________________________

Phone # ______________________________

Reason ______________________________

Have you ever been admitted to a hospital? Yes No

If Yes brief explanation of when and why _____

____

____

Have you ever had previous operations? Yes No

If Yes brief explanation of when and why_____

____

____

Blood Pressure

Enter last BP and Date ______________________________

Is the patients BP generally Abnormally High Abnormally Low Neither

Has he/she ever had...(circle all that apply)

Heart Problems

Heart Attack/MI, Angina/chest pain, Hypertension, Prosthetic Heart Valve, Congestive Heart Failure, PaceMaker/Defibrillator, Infective Endocarditis, Heart Palpitations, Irregular Heartbeat, Rheumatic fever, Rheumatic heart disease

Please give any information that you feel is important to know about the circled issues

____

Breathing Problems

Asthma, Tuberculosis, Sleep Apnea, Bronchitis/emphysema/COPD, Cough, Shortness of breath, Pneumonia

Please give any information that you feel is important to know about the circled issues

____

Blood Problems

Anemia, Sickle cell disease, HIV/AIDS, Bleeding disorders (Coumadin, hemophilia), Warfarin treatment, Bruising easily

Please give any information that you feel is important to know about the circled issues

____

Head, Eyes, Ears, Nose or Throat Problems

Frequent Headaches, Jaw joint/TMJ popping, catching, or pain, Glaucoma, Sinus/Nasal

Please give any information that you feel is important to know about the circled issues

____

Digestive Problems

Hepatitis/Jaundice, Liver disease, GERD/reflux/ulcers

Please give any information that you feel is important to know about the circled issues

____

Endocrine Problems

Diabetes or Thyroid disorder

Please give any information that you feel is important to know about the circled issues

____

Nervous System Problems

Stroke/TIA/Mini Stroke, Epilepsy/Seizure Disorder, Neuropathy/Nerve Pain

Please give any information that you feel is important to know about the circled issues

____

Psychiatric Problems

Depression, Panic/Anxiety Disorder, Other Psychiatric/Emotional Disorder

Please give any information that you feel is important to know about the circled issues

____

Other Problems

Renal/Kidney/Prostate disease, Organ Transplant, Cancer/Tumors,
Radiotherapy/Chemotherapy, Arthritis, Joint Replacement,
Other: ____

For Women Only

Are you nursing?	Yes	No
Are you or could you be pregnant	Yes	No

Family History Of... (circle all that apply)

Cancer
Arthritis
Heart Disease
Hypertension
Anesthesia Complications

Has he/she ever used... (circle all that apply)

Tobacco
Alcohol
Recreational Drugs

Is he/she ALLERGIC to... (circle all that apply)

Aspirin
Iodine
Pain Medicine
Penicillin/Amoxicillin
Other Antibiotics — Please List: ________________________
Local Anesthetics
Other Medicines — Please List: ________________________
Latex Gloves or Powder
Environmental/Seasonal Allergies

Other Allergies Please List: ______________________________

Medications (circle all that apply) **Provide copy of list if possible

Anticoagulants (blood thinners)
Aspirin
Coumadin
Plavix
Bisphosphonates (Boniva, Reclast, Fosamax, Aredia, Zometa)
Steriods
Birth Control
Other Medicines/Supplements **Please list:** ______________________________

____
____
____
____
____

Patient Name: ______________________________

Patient/Guardian Signature: __________________________

Date: ____________________

Patient's Name: ______________________________ Date: ________________

Date of Birth: ____________________

Name and **complete** address of patient's dentist: ______________________________________

____

Developmental Disability: ____

Dental Screening:

___ ***YES***, I want to receive a dental screening

Oral Hygiene Training:

___ ***YES,*** I want to receive **routine** hands-on oral hygiene training and monitoring

Fluoride Varnish Treatment:

___ ***YES,*** I want to receive **routine** fluoride varnish treatments

Are you allergic or sensitive to any form of dentifrice (toothpaste) and/or fluoride? YES NO

__________________________ ____________________

Patient/Parent/Guardian Signature Date

A dental screening (charting) may be performed. The screening has limitations and is not a substitute for a comprehensive dental examination. The purpose of dental charting is to collect data. The Special Needs Dentistry: Community Outreach Program strongly advises each participant to receive a complete examination by a dentist who can render a professional diagnosis of his/her oral health needs. The diagnosis of caries, soft tissue disease, oral cancer, tempro-mandibular joint disease (TMJ), and dentofacial malocclusions can only be completed by a dentist in the context of delivering a comprehensive dental examination. The preventive services are in place to help support and enhance the participant's current dental care and to offer assistance to those who are lacking in such supports. Open communication with any existing dentist is encouraged; and for those who are without a dentist, a referral to our existing program can be made by the dental hygienist.

Dental Hygienist: Whitney Tilman **Signature:** ______________________________

License Number: DH21972 **Place of Employment:** University of Florida College of Dentistry

Location where dental charting was performed: ______________________________

(Rev 10/8/14)

Patient Supplemental Form

Patient's Name: ______________________
Parent/Guardian: ______________________

Developmental Disability: ____

Describe patient's communication process: ______________________________________

Does he/she have difficulty with hearing or visions? Yes No
If yes, please explain ____

Are there any specific physical/behavioral challenges that we should be aware of? Yes No
If yes, please explain ____

Has he/she visited the dentist before? Yes No
If yes, please describe tolerance for dental experience ______________________________
____

Is he/she able to brush independently without parent/caregiver assistance? Yes No
Does he/she regurgitate or pocket food between cheeks or lips? Yes No
Does he/she have gastroesophageal reflux or episodes of vomiting? Yes No
Does he/she experience dry mouth? Yes No

Contact/Offsite Visitation Location Info

Does he/she live in a group home? Yes No
If Yes please provide the following: **Name of Group Home** ______________________________
Address ______________________________________
Phone Number ______________________________________
Who to contact to schedule visits ______________________________
Phone Number ______________________________________

Does he/she attend an Adult Day Training Program? Yes No
If yes please provide the following: **Name of program** ______________________________
Address ______________________________________
Phone Number ________________ **Supervisor** ________________
Week days he/she attends program ______________________________

**The Special Day Foundation provides a bi annual newsletter discussing updates about the program as well as upcoming events. Educational topics/information for parents and caretakers will also be provided in each newsletter. Provide your email address below if you would like to receive the Special Day Foundation newsletter.

Email ______________________ Patient's Email ______________________________

Dedication through special needs philanthropy

Notice of Participant Responsibility Policy:

Special Day Foundation works with the University of Florida through its St. Petersburg Dental Clinic to improve access to dental funding and services for individuals with developmental disabilities. The Clinic provides a multitude of specialized services to a considerable number of local citizens who desperately need this care. Special Day Foundation does its best to raise funds to pay for care that individuals with special needs cannot afford.

To offer this program to as many patients as possible, a tremendous amount of coordination is needed to make sure that the right staff and equipment are secured. When a participant fails to present to an appointment or cancels an appointment on short notice, it prohibits the Dental Clinic from being able to provide care for another individual and, in most cases, costs the Clinic for the time of professional staffing while providing no care. **It is imperative that you attend each appointment once it has been scheduled.**

Please initial all 4 statements and sign below.

____ I understand that Special Day Foundation follows and supports St. Petersburg Dental Clinic's cancelled/failed appointment policy.

____ I understand that if I fail or cancel an oral sedation, IV sedation, or an operating room appointment, all services will cease from the cancelled/failed appointment date forward, unless significant reason has been reviewed and approved by the Director of the Dental Clinic.

____ I understand that once all insurance options have been exhausted, funds for dental care may be provided by Special Day Foundation to help with expenses associated with dental care. Costs approved by Special Day Foundation to assist in payment will be shared with you prior to the start of any treatment. There is no guarantee that Special Day Foundation will cover all remaining costs.

____ I understand that Special Day Foundation will not commit to funding dental care that will be rendered during operating room appointments unless the operating room fee will be covered by insurance.

______________________________	______________________________
Participant Name	Guardian Name
______________________________	______________________________
Participant/Guardian Signature	Date

P.O. Box 119 • Bradenton Beach, FL 34217-0119 • TEL 941.225.3103
SPECIALDAYFOUNDATION.org

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AUTHORIZATION to Use or Disclose Protected Health Information for Marketing, Fundraising, Publication, or Public Relations

Patient's Name X		*Date of Birth* X	*Verification of Identity (Driver's License, ID Card, Passport, etc.)*
Patient's Address X			
Phone # X	*Phone #*	*Email Address* X	*Health Record Number*

***** Complete the following only if the person authorizing the use or disclosure is not the patient:***

Representative's Name		*Relationship to Patient*	*Legal Authority*
Representative's Address		*Verification of Identity*	*Verification of Authority*
Phone #	*Email Address*		

By signing this form, I authorize the following:

The PHI that may be used or disclosed is **from**:		The PHI may be **used by** or **disclosed to**:	
Person, class of persons, or organization UFCD		*Person, class of persons, or organization*	
Address 9200 113th St		*Address*	
Seminole Fl 33772			
Attn:	*Phone* 727 394-6064	*Attn:*	*Phone*

The following protected health information may be disclosed: *Check all that apply:*
☒ My Name ☐ Address ☐ Diagnosis ☐ Treatments ☐ Prognosis ☒ Photograph(s)
☐ Physician or care-giver's name and specialty ☐ Treating Department or Clinic ☐ Testimonial(s)
Other: ____________________

I further authorize the disclosure of the following information which may be included in the protected health information listed above. (*Check all that are approved.*)
☐ Mental Health ☐ Substance Abuse ☐ HIV/AIDS

This Health Information is being used or disclosed for: *Check all that apply:* ☐ Public Relations Activities
☐ Marketing Activities ☒ Fundraising/Promotional Activities ☒ Educational Purposes Outside of UF
Other: ____________________

I understand that, by federal law, the University of Florida may not use or disclose protected health information without authorization except as provided in the University's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.
I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.
I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.
I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.
I have the right to receive a copy of the Health Information released.

This authorization expires automatically for further uses or disclosures of the above described PHI:
After: ☐ **1 Year** ☐ **2 Years** ☐ **Upon written revocation.**

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative: X	*Date*

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UFCD Patient Registration

Patient's Full Name: ______________________________ Date: ______________

Home Address: ______________________________ Zip Code______________

Home Phone: ____________________ Date of Birth: ____________ Sex: ________

Parent/Guardian's Full Name: ____

Emergency Contact:

Name: ____________________________ Phone: ______________________

Relationship: ____

If the Parent/Guardian's address is different than above, complete the following:

Address: ____

Phone: ________________________________

Primary Insurance Company Information:

Name of Insurance Company: _______________________ Phone: ______________

Address: ____

Insurance/Group Number: _______________________________

Medicaid No: _____________________ Medicare No: __________________

If the policy holder is not the patient, then complete the following:

Name: ____

Address: ____

Date of Birth: ______________ Patient's Relationship to Insured Party: ____________

The optional demographic and financial information is being asked to better understand the individuals served by the College of Dentistry. This information is used to request additional funds from the government and other sources to help keep the cost of dental care affordable to our patients.

Gross Annual Household Income: ____________________ Number in Household: ___________

Ethnic Origin: ________________

I give the University of Florida College of Dentistry permission to bill all applicable insurance(s) for preventative service rendered through the Special Needs Dentistry: Community Outreach Program. I understand that if the treatment is not covered by insurance, Special Day Foundation will fund the dental screening, oral hygiene training, and/or fluoride varnish treatment provided at the organization's facility.

Patient/Parent/Guardian Signature ___________________________ Date: _______________

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College of Dentistry

Patient Rights and Responsibilities

Patients:
Please carefully read, sign and date this form. If you have any questions or concerns about your rights or responsibilities, please do not hesitate to discuss them with your provider. If they are not resolved, you may contact the patient advocate:
(352) 273-6825 or visit the Patient Registration desk.
– Thank you – UF College of Dentistry

As a comprehensive care patient of the University of Florida College of Dentistry you have certain rights during your course of treatment.

- You have the right to considerate, respectful and confidential treatment.
- You have the right to a complete and thorough dental examination and the right to a thorough review of your medical history especially as that history may relate to your dental condition.
- You have the right to a complete treatment plan of your dental needs, explained completely to you in a manner so that you understand those needs. You have the right to have input into that treatment plan so that your personal concerns regarding treatment needs are addressed. Treatment options including risks and costs associated with your proposed dental treatment.
- You have the right to have your treatment needs completed promptly and on a scheduled basis. You have the right to emergency dental care through your dentist of record or another provider if referred.
- You have the right to impartial access to dental treatment regardless of race, national origin, religion, sexual orientation or physical handicap. You have the right to special help if you have a disability.
- You have the right to consult with a patient advocate if a problem develops during your treatment which you cannot resolve. You may contact the patient advocate at (352) 273-6825 or at Patient Registration.

As a patient you also have certain obligations.

- You have an obligation to keep all dental appointments. Failure to keep, or appropriately cancel an appointment, may result in a cancelation charge or discharge as a patient.
- You have an obligation to pay for your dental treatment as that treatment is delivered. Treatment cannot continue if you fail to pay in a timely fashion.
- You have an obligation to do your part to maintain your dental health. You must floss, brush, etc., and return for any scheduled recalls to do your part to ensure the longevity of your dental treatment.
- You have an obligation to provide the clinic with accurate and comprehensive personal information related to your health, demographics, and contact information.

I certify that I have read, understand and agree to the above rights and obligations.

X_______________________

Revised 3/26/2009

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ACKNOWLEDGMENT OF RECEIPT

I have been provided a copy of the Shands HealthCare* and the University of Florida Health Science Center's** Notice of Privacy Practices. I understand that I may ask questions about this notice at any time.

Patient Name: ____

Patient or Legal Guardian's Signature (if Patient is under 19): ___________________________________

Date: _________________________

* Shands HealthCare consists of Shands Teaching Hospitals and Clinics, Inc., Shands at Lake Shore, Inc., and Shands Jacksonville Medical Center, Inc.

** University of Florida Health Science Center consists of the UF Health Science Center clinics and physicians offices; the Florida Clinical Practice Association; the University of Florida Jacksonville Physicians, Inc., the University of Florida Jacksonville Healthcare, Inc., the University of Florida Colleges of Medicine, Nursing, Health Professions, Dentistry and Pharmacy; and other affiliated health care providers.