

DOH Okaloosa County Medical History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's (doctor's) care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs? Please list the medications.	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you currently having any dental pain or problems? If so, please note	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Comments:

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local Anesthetics

Other allergies?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
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Are you pregnant? If so, give due date.	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
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Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No	Convulsions	<input type="radio"/> Yes <input type="radio"/> No
Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
ADD/ADHD	<input type="radio"/> Yes <input type="radio"/> No						

Have you ever had any serious illness not listed	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
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I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I also understand that before treatment is provided, I have the right to have benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Signature of Patient, Parent or Guardian:

X

Date: _____



Patient Demographic and Financial Information

Section 1: Client Information

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Gender: M F (please circle) Social Security #: _____
Language: _____ Race: _____
Ethnicity: Hispanic Non-Hispanic (please circle)
Communication Preference: (please circle) Mail Cell Phone Home Phone Work Phone Other Phone
Email _____ Text No Preference
Home Phone: _____ Cell Phone: _____
Would you like to receive text message reminders of appointments? Y N
Address: _____ City: _____ State: _____
Country of Birth: _____ Date Arrived in U.S.: _____
Have you lived outside the U.S. longer than 2 months? Y N If yes, What Country? _____
Are you a migrant worker? Y N Are you a seasonal agricultural worker? Y N
Immigration Status: _____ Alien #: _____
Country Mother Born In: _____ Country Father Born In: _____
Highest Level of Education (last grade completed): _____ Are you a military veteran? Y N
Do you have: Medicaid? Y N Private Medical Insurance? Y N Private Dental Insurance? Y N

Section II: Parent/Guardian Information (If client is over 18 go to Section III)

Parent/Guardian Names: _____
Parent/Guardian Address: _____ City: _____ State: _____
Parent/Guardian Home Phone: _____ Parent/Guardian Cell Phone: _____

Section III: Emergency Contacts

Emergency Contact Name: _____
Emergency Contact Address: _____
Emergency Contact Phone: _____

Section IV: Financial Information (List everyone in your household)

Name	Date of Birth	Relationship	Name	Date of Birth	Relationship

Signature: _____ Print Name: _____

Relationship to Client: Self Parent Guardian (please circle) Date: _____

****By signing this form, I give consent for the Florida Department of Health in Okaloosa County to contact the person(s) listed as emergency contact(s) on this form.****



Authorization for Non-Parent Consent and/or Guardian to Consent for Dental Exam and/or Treatment

As the parent or legal guardian of

_____, _____

(Child's Name)

(Date of Birth)

I give permission for the following to bring my child to the clinic. The persons listed below can make decisions and authorize treatment for my child. This includes but is not limited to exam, x-ray, cleaning, sealants, fillings, "root canals", removing a tooth, emergency treatment. I understand some treatments may require local anesthesia.

Please initial all that apply.

☐ **No one** else can bring my child to the clinic.

☐ Okaloosa County Head Start.

☐ _____
(Person bringing child to clinic – must be 18 or older) (relationship to child)

☐ _____
(Person bringing child to clinic – must be 18 or older) (relationship to child)

☐ _____
(Person bringing child to clinic – must be 18 or older) (relationship to child)

☐ _____
(Person bringing child to clinic – must be 18 or older) (relationship to child)

Parent/Guardian: _____
(Circle one) (Please print)

Address: _____

City: _____ State: _____

Home Phone: _____ Cell: _____

Parent/Guardian Signature

Date

Witness Signature

Date

UPDATE

Parent/Guardian Signature

Date

Witness Signature

Date

WITHDRAWAL OF CONSENT

I _____ withdraw this consent, effective _____.
Parent/Guardian Signature Date



Broken Appointment Policy

We are one of the few dental clinics in Okaloosa County that sees kids with Medicaid. More children need dental care than we have space to see. When children are late or don't come to their appointment the time is lost. Another child could have used that time to get the dental care they needed. Our clinic has a *Broken Appointment Policy* to make sure our clients can get the dental appointments that they need.

Broken Appointment Policy

- Missed appointments are broken appointments. To cancel an appointment, call the clinic at (850) 689-5593. You can leave a message.
- Call the clinic at least 24 hours before the appointment time if you need to cancel your appointment. If your appointment is on Tuesday at 10 am, you must call us the day before (Monday) by 10 am. This lets us schedule other children who need dental care.
- Arrive on time for the dental appointment. If you are late we may need reschedule your appointment. A late reschedule is a broken appointment.
- If you have two (2) broken appointments your child cannot be scheduled for six (6) months. After six months, you can call to make an appointment.
- If your client has two (2) more broken appointments, they will be dismissed from the dental program. You will need to find another dental clinic. We will send the dental records to your child's new dentist when we receive a written request.
- You will receive a phone and/ or text reminder for your child's appointment. If your phone number changes at any time please let us know.

We want your child to have the best dental care. We work hard to make dental care available to every child. Please call us if your new phone number changes at any time.

I have read and understand this policy. I had a chance to ask questions and my questions about this policy have been answered. I understand that breaking my dental appointments results in losing the ability to schedule appointments or being dismissed from the dental program.

Client Representative Signature

Self or Representative's Relationship to Client

Date



INITIATION OF SERVICES

PART I. CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: _____

Agency Address: _____

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

PART II. DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III. COMMUNICATIONS

I understand the Florida Department of Health (DOH) uses a patient portal to communicate with me about my health care. In order to receive electronic communications about my health care, I need to provide my email address to the department and then I will be contacted by email to create a portal account.

I understand that I must agree to the terms and conditions of use associated with the portal when I create my account. I understand that the portal is password protected and that I am responsible for maintaining the confidentiality of my username and password and for all activities that are conducted through my portal account. I understand that I will receive emails letting me know that DOH has sent information to the portal.

_____ Initial here to **authorize** and give my express consent to the DOH to make your health care information available to you through the portal.

Email Address: _____

I understand that I have a right to stop participation in the portal at any time by either removing my email address or closing my portal account.

_____ Initial here to **remove your email** address from the DOH system and stop receiving information through the portal.

PART IV. MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART V. ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART VI. COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VII. MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

Client/Representative Signature _____

Self or Representative's Relationship to Client _____

Date _____

Witness (optional) _____

Date _____

PART VIII. WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____ Client/Representative Signature

Witness (optional) _____

Date _____

Original to file; Copy to client

Client Name: _____

ID#: _____

DOB: _____



Informed Consent for Dental Treatment

Client Name: _____ DOB: _____

The Dentist explained, and I understood the:

- Condition of my child's teeth,
- Preferred treatment,
- Risks of treatment including those specific to my child,
- Expected treatment results,
- Likely treatment results,
- Other treatment options and risks, and
- Risks of NO treatment.

I understand:

- Dentistry is not an exact science.
- The Dentist cannot promise results.
- There may be other conditions found while the Dentist is working on my child's teeth. The Dentist may need or find it best to change treatment or add a procedure.
- Some conditions make other unexpected treatment needed. This would be determined on a case by case basis. The most common is the need for a root canal during or after a routine filling. Those treatments should occur when noticed rather than waiting to get a new consent.

I had a chance to talk with the Dentist and ask questions about my child's teeth. I have been told about the treatment needed, risks, benefits and other options.

I give permission to the Dentist to make changes or additions, in their professional opinion, as needed or preferred to meet my child's dental needs.

I consent to the dental treatment listed on the attached treatment plan as proposed.

Client's Parent/Guardian Signature

Relationship to Client

Date



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.

INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction. However, in situations where you or someone on your behalf pays for an item or service in full, and you request information concerning said item or service not be disclosed to an insurer, the Department will agree to the requested restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.

DEPARTMENT OF HEALTH DUTIES

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).
HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).