Time 2:54 PM | Okaloosa County Health Department | Date 10/3/2014

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?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs? Please list the medications.	◯ Yes ◯ No	If yes
Are you currently having any dental pain or problems? If so, please note	◯ Yes ◯ No	If yes

Comments:

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other allergies?	◯ Yes ◯ No	If yes
Are you pregnant? If so, give due date.	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed	◯ Yes ◯ No	If yes

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 satifaction.

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)

the following have permission to bring my child to the Florida Department of Health in Okaloosa County for services in the event of my absence. (Please check all that apply).

☐ Parent or Legal Guardian ***Only***

☐ Okaloosa County Comprehensive Head Start Development, Inc.

☐ _____ _____
(Individual bringing child in for visit – must be 18 or older) (relationship to child)

☐ _____ _____
(Individual bringing child in for visit – must be 18 or older) (relationship to child)

☐ _____ _____
(Individual bringing child in for visit – must be 18 or older) (relationship to child)

☐ _____ _____
(Individual bringing child in for visit – must be 18 or older) (relationship to child)

I give my consent for the above named individual(s) to make informed consent decisions and to authorize dental treatment regarding my child's examination and dental treatment including but not limited to: medical history, x-rays, cleanings, sealants, fillings, "root canals", teeth extractions (removal) and emergency exam and treatment, as deemed necessary in my absence. Some of the treatments may involve administering local anesthesia. I also understand that I must revoke this consent in writing and furnish a copy to the Florida Department of Health in Okaloosa County prior to services being rendered to my child if I change my mind after signing this consent.

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

Address: _____

City: _____ State: _____

Phone #: _____ Cell #: _____

Parent/Guardian Signature	Date	Witness Signature	Date

Updated			
Parent/Guardian Signature	Date	Witness Signature	Date

Revoked			
Parent/Guardian Signature	Date	Witness Signature	Date

Broken Appointment Policy

We are one of the few dental clinics in Okaloosa County that sees kids with Medicaid. More families want dental care for their children than the number of spaces we have available. When a client does not show up or is late, that appointment has been wasted. Another child could have used that appointment to get the dental care they needed. To help all our children get the dental appointments they need we have a new *Broken Appointment Policy.*

If you need to cancel an appointment, you must call the dental clinic at least 24 hours before the appointment time. If your appointment is on Tuesday at 10 am, you must call us the day before (Monday) by 10 am. If your family has two or more appointments scheduled on the same day, you must call us 48 hours, or two work days before the appointment. So, for appointments on Tuesday at 10 am, you must call us by Friday at 10 am. This lets us schedule another child who needs dental care into the appointment time. Missed appointments that are not cancelled are broken appointments. To cancel an appointment call the dental clinic at (850) 689-5593. You can leave a message to cancel.

Please arrive on time for your appointment. If you are late, you are taking another child's appointment time. If this happens we may reschedule your appointment. This is also a *broken appointment.*

After two (2) broken appointments, an appointment cannot be scheduled for six (6) months. After six months, you can call to be readmitted to the dental program and make an appointment.

If a client has two (2) more broken appointments after they are readmitted, they will be dismissed from the dental program. You will need to find another dental clinic for appointments. We will send the client's dental records to the new dental clinic as soon as we receive their request in writing.

We want your child to have the best dental care. We work hard to make dental care available to every client. We try to call all of our families the day before their scheduled appointment. This is a reminder call and lets us give families any information they need before their appointment. When needed, we work with families to reschedule their appointments as soon as possible. Please be sure you call and give us your new phone number if it changes.

I have read and understand the *Broken Appointment Policy.* All of my questions about this policy have been answered. I understand that breaking my dental appointments will result 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
_____	_____	
Witness	Date	

Florida Department of Health In Okaloosa County
810 E James Lee Blvd, Crestview, FL 32539 PHONE: 850/689-7808 • FAX 850/689-5928

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 Date

Witness (optional)	Date

Client Name: _____

ID#: _____

Original to file; Copy to client

DOB: _____

Informed Consent for Dental Treatment

Whenever dental treatment is performed, there is always a risk of complications due to unexpected problems.

The dentist has explained my/my child's dental condition and the proposed treatment. I understand the risks of treatment, including the risks that are specific to me/my child, and the likely outcomes. The dentist has explained other relevant treatment options and their associated risks. The dentist has explained my/my child's prognosis and the risks of NOT having the treatment.

I was able to ask questions and raise concerns with the dentist about my/my child's condition, the treatment and its risks, and the treatment options. These have been discussed and answered to my satisfaction.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth. These conditions cannot be anticipated, the most common one being the need for "root canal therapy", resulting during or following routine "fillings". I give permission to the Dentist to make any/all changes and additions necessary to meet my/my child's dental needs.

I understand that dentistry is not an exact science; therefore, the Dentist cannot fully guarantee results. I hereby consent to the dental treatment listed on the attached treatment plan as proposed.

_____ _____

Patient, Parent or Guardian Signature Date

_____ _____

Dentist's Signature Date

Client Name: _____

ID: _____

DOB: _____

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