

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?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs? Please list the medications.
Are you currently having any dental pain or problems? If so, please note

Comments:

[Empty text box for comments]

Are you allergic to any of the following?

- Aspirin, Metal, Penicillin, Latex, Codeine, Sulfa Drugs, Acrylic, Local Anesthetics

Other allergies?
Are you pregnant? If so, give due date.

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

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

Have you ever had any serious illness not listed

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)

Table with 6 columns: 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



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 visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

_____ By initialing this line, I acknowledge that I have been provided with a Telehealth Informed Consent Informational Sheet and that I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

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

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt-Out form.

PART III 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 health 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 IV 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 V 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 VI 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 VII WITHDRAWAL OF CONSENT

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



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: _____