DENTAL HEALTH HISTORY

Name: _____
ID No. _____
Date: _____

In the following questions, circle **Yes** or **No**, whichever applies. Your answers will be considered confidential.

1. Do you **(PATIENT)** have or have you **(PATIENT)** had any of the following:

Rheumatic Fever or Heart Murmur	Yes No	Neurological Problems	Yes No
Heart Trouble or Shortness of Breath	Yes No	Tuberculosis (TB) or Persistent Cough	Yes No
High or Low Blood Pressure	Yes No	Diabetes or Excessive Thirst	Yes No
Fainting or Dizzy Spells	Yes No	Epilepsy or Seizures	Yes No
Stroke	Yes No	Kidney Problems or Excessive Urination	Yes No
Anemia or Blood Problems	Yes No	Liver Problems or Hepatitis	Yes No
Sickle Cell Anemia	Yes No	Venereal Disease	Yes No
Excessive Bleeding or Bruise Easily	Yes No	AIDS/ARC/HIV Positive	Yes No
Blood Transfusions	Yes No	Cancer Yes No	
Allergies or Skin Rash	Yes No	Pregnancy	Yes No
Asthma	Yes No	Trimester 1 2 3	
Thyroid Problems	Yes No	Painful or Swollen Joints	Yes No
Emotional Problems	Yes No	Other _____	Yes No

2. Are you **(PATIENT)** currently under the care of a physician (doctor)? Yes No
If yes, list name of doctor. _____

3. Have you (PATIENT) been hospitalized in the last 2 years? Yes No

If yes, why? _____

4. Are you **(PATIENT)** currently taking any medications, pills or drugs? Yes No

If yes, list. _____

5. Are you **(PATIENT)** allergic to or have you ever experienced any ill effect from a local anesthetic (novocain), penicillin, or any drugs/pills? i.e., rash, itching or fainting. Yes No

If yes, describe. _____

6. Have you **(PATIENT)** ever experienced any unfavorable reaction from previous dental treatment? Yes No

If yes, describe. _____

7. Are you **(PATIENT)** currently having any dental pain or problem? Yes No

If yes, describe. _____

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 the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Signature of Patient _____ Date _____

(If patient is a child, parent or legal guardian must sign) Relationship _____

Comments by Dentist: _____

_____

_____

Signature of Dentist _____ Date: _____

DH 3117, 10/96 (Part 5) (Replaces HRS-H Form 3117, part 5, which may be used) (Stock Number: 5744-005-3117-7)

Dental Health History Review/Update:

1. Comments:

Patient: _____

_____

Dentist: _____

Date _____ Patient's Signature _____Dentist's Signature _____

2. Comments:

Patient: _____

_____

Dentist: _____

Date _____ Patient's Signature _____ Dentist's Signature _____

3. Comments:

Patient: _____

_____

Dentist: _____

Date _____ Patient's Signature _____ Dentist's Signature _____

4. Comments:

Patient: _____

_____

Dentist: _____

Date _____ Patient's Signature _____ Dentist's Signature _____

5. Comments:

Patient: _____

_____

Dentist: _____

Date _____ Patient's Signature _____ Dentist's Signature _____

6. Comments:

Patient: _____

_____

Dentist: _____

Date _____ Patient's Signature _____ Dentist's Signature _____

7. Comments:

Patient: _____

_____

Dentist: _____

Date _____ Patient's Signature _____ Dentist's Signature _____

8. Comments:

Patient: _____

_____

Dentist: _____

Date _____ Patient's Signature _____ Dentist's Signature _____

State of Florida Department of Health

Notice of Privacy Practices Acknowledgement Form

Name: _____ **Client ID#** _____

Facility/Site/Program: Florida Department of Health, Dental Clinic

I have received a copy of the DOH Notice of Privacy Practice Form DH 150-741, 09/13.

Signature: _____ Date: _____

Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name: _____ Role: _____

(Parent, guardian, etc.)

Witness: _____ Date: _____

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgement obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgement could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on _____
(Date)

_X_ Face to face meeting
__ Mailing
__ Email
__ Other_____

Reason Individual Representative did not sign this form:

__ Individual or Representative chose not to sign
__ Individual or Representative did not respond after more than one attempt
__ Email receipt verification
__ Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., dates(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than one attempt must been made.

__ Face to face presentation(s) _____
__ Telephone contact(s) _____
__ Mailing(s)_____
__ Email _____
__ Other _____

Staff Signature: _____ Title: _____

Print Name: _____ Date: _____

This form must be retained for a period of at least six years in the appropriate record.

State of Florida Department of Health

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below. Then read and sign the section at the bottom of form.

Patient Name _____

1. WORK TO BE DONE
I understand that I am having the following work done: Fillings__ Bridges__ Crowns__ Extractions__ Impacted teeth removed__ Local Anesthesia__ Root Canals__ Other_____
(Initials_____)

2. DRUGS AND MEDICATIONS
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain. Itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
(Initials_____)

3. CHANGES IN TREATMENT PLAN
I understand that during treatment It may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary
(Initials_____)

4. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks Involved In having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an Indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which Is my responsibility.
(Initials_____)

5. PERIODONTAL LOSS (TISSUE & BONE)
I understand that I have a serious condition, causing gum and bone infection or loss and that it cart, lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.
(Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ Date_____

Signature of Parent/Guardian if patient is a minor_____ Date_____

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: Florida Department of Health- Dental Clinic **Phone #:** 239-252-3514

Address: 3339 E. Tamiami Trl Building H Naples FL 34112 **Fax #:** 239-252-5396

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ **Phone #:** _____

Address: _____ **Fax #:** _____

Other method of communication: _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Record(s), including STD and TB
_____ Progress Notes
_____ Immunizations
_____ History and Physical Results
_____Family Planning
_____Prenatal Records
_____ Consultations
_____ Diagnostic Test Reports (Specify Type of test(s))
_____
_____ Other: _____

I specifically authorize release of information relating to: (initial selection)

_____HIV test results for non-treatment purposes
_____Substance Abuse Service Provider Client Records
_____Psychiatric, Psychological or Psychotherapeutic notes
_____Early Intervention
____ WIC
____ Dental History
____ Dental X-Rays

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.
REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.
REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ Client/Representative Signature

_____ Date

_____ Printed Name

_____ Representative's Relationship to Client

_____ Witness (optional)

_____ Date

Client Name: _____
ID#: _____
DOB: _____

INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: Florida Department of Health, Dental Clinic

Agency Address: 3339 E. Tamiami Trl Building H Naples, FL 34112

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 the 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 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 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 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 VI WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature Date

_____	_____
Witness (optional)	Date

.

Client Name:_____

ID#: _____

DOB: _____

DH 3204, [Approved November 2008],

Original to file Copy to client

Permission for Dental Examination and/or Treatment of a Minor

I am the parent or guardian of _____
who is a minor child, and I do hereby authorize and consent to any x-ray, examination, anesthetic, or dental treatment rendered under the general, direct, or indirect supervision of Collier County Health Department Dental Clinic, its associates, staff members, or agents, as may deem necessary.

In the event that I am unable to be present with my child, I give permission and assign _____ to accompany my child to your clinic.

This authorization will remain in effect until cancelled in writing by me.

Parent
Signature _____ Date _____

Witness_____

Note. - This document must be accompanied by a document with picture in it, whether driver's license or I.D

BROKEN APPOINTMENT POLICY

PLEASE READ CAREFULLY AND SIGN

WHEN APPOINTMENTS ARE MADE WE DO EXPECT THEM TO BE KEPT. THESE APPOINTMENTS ARE MADE FOR YOUR CONVENIENCE. OUR TIME IS VERY VALUABLE. IF YOU FAIL TO KEEP AN APPOINTMENT YOU ARE DEPRIVING SOMEONE ELSE OF THIS TIME.
;
PLEASE KEEP YOUR APPOINTMENTS AND BE HERE **20 min BEFORE** YOUR TIME. IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENTS PLEASE NOTIFY US AT LEAST 24 HOURS IN ADVANCE. LESS THAT 24 HOURS NOTICE WILL BE CONSIDERED A BROKEN APPOINTMENT.

IF YOU BREAK ONE APPOINTMENT YOU WILL NOT BE SEEN IN THE CLINIC FOR THREE MONTHS. IF YOU BREAK TWO APPOINTMENTS YOU WILL BE DISMISSED FROM THE CLINIC FOR ONE YEAR. TRUE EMERGENCY VISITS WILL CONTINUE TO BE SEEN, IF NEEDED.

YOUR CHILD'S DENTAL HEALTH IS EXTREMELY IMPORTANT FOR THE OVERALL HEALTH OF YOU CHILD! PLEASE TAKE THESE APPOINTMENTS SERIOUSLY!

I AM AWARE THAT FINANCIAL ELIGIBILITY IS DUE EVERY YEAR. IT IS MY RESPONSIBILITY TO BRING IN THE DOCUMETS REQUIRED TO UPDATE MY FINANCIAL RECORDS. THESE DOCUMENTS INCLUDE:

1. My social security card along with my child's
2. Proof of residency such as a driver's license or utility bill
3. Proof of income such as:
    a. Paycheck stubs for one month
    b. Proof of child support
    c. Disability check
    d. Unemployment check
    e. Social Security check

I UNDERSTAND THAT IF I DO NOT BRING IN THE REQUIRED DOCOUMENTS I WILL HAVE TO PAY 100% OF THE FEE.

I HAVE READ AND I UNDERSTAND THE ABOVE STATEMENTS

_____ _____
SIGNATURE DATE

Collier County Health Department-Dental Department

Name of Head of household
Nombre del Cabeza de Familia

Date of Birth
Fecha de Nacimiento

Gender
Genero ☐ F ☐ M

Social Security #
Numero de Seguro Social

Street Address
Dirección Residencial

City
Cuidad

State
Estado

Zip Code
Código Postal

Telephone Number
Numero de Teléfono

Cellular Telephone Number
Numero de Teléfono Celular

Medicaid # /Numero de Medicaid

Income /Ingreso $

☐Weekly Semanal ☐Biweekly Cada dos semana ☐Monthly mensual ☐Yearly anual

Employer

Family Members: (Living in your household)
Información sobre la familia (que viven con Usted)

	Name Nombre y Apellido	Gender Genero	Date of Birth Fecha de Nacimiento	Social Security Seguro Social
1		☐F ☐M	/ /	- -
	Medicaid Number: Numero de Medicad:		Income / Ingreso	$
2		☐F ☐M	/ /	- -
	Medicaid Number: Numero de Medicad		Income / Ingreso	$
3		☐F ☐M	/ /	- -
	Medicaid Number: Numero de Medicad		Income / Ingreso	$
4		☐F ☐M	/ /	- -
	Medicaid Number: Numero de Medicad		Income / Ingreso	$
5		☐F ☐M	/ /	- -
	Medicaid Number: Numero de Medicad		Income / Ingreso	$
6		☐F ☐M	/ /	- -
	Medicaid Number: Numero de Medicad		Income / Ingreso	$