TODAY'S DATE: ______________________

DO YOU HAVE AN APPOINTMENT: YES / NO

INITIAL VISIT

PATIENT NAME: ______________________ DATE OF BIRTH: ______________

PATIENT SOCIAL SECURITY NUMBER: ______-______-______ SEX: M / F RACE: __________

PRIMARY LANGUAGE SPOKEN: ______________ HISPANIC: YES / NO PREGNANT: YES / NO

ADDRESS: ____

MAILING ADDRESS: ____

HOME PHONE #: ______________ CELL PHONE #: ______________ OTHER PHONE #: ___________

CURRENT SCHOOL: ____

MEDICAID ID NUMBER: ______________________ (PLEASE PROVIDE INS. CARD)

WHEN WAS THE PATIENT LAST SEEN BY A DENTIST: ________ REASON SEEN: ______________

WHAT TREATMENT WAS DONE: ____

DENTIST'S NAME: ______________________ WERE X-RAYS TAKEN: YES / NO

DENTIST'S LOCATION, PHONE #: ____

____

FULL NAMES OF ALL PERSONS IN THE FAMILY	DATE OF BIRTH	RELATIONSHIP TO PATIENT

Updated 11/2/15

INITIATION OF SERVICES

PART I. CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: ____________________

Name of Agency: Florida Department of Health in Putnam County

Agency Address: 2801 Kennedy Street Palatka, FL. 32177

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#: ______________________

DOB: ______________________

Original to file: Copy to client

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatments or the option of no treatment.

It is very important that you provide your dentist with an accurate medical history before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre-and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. Do not sign this form or agree to treatment until you have read, understood and accepted each item carefully. Be certain your dentist has addressed all your concerns to your satisfaction before commencing treatment.

During your course of treatment, the following care may be provided to you:

- **EXAMINATIONS AND X-RAYS** Radiographs are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided by the dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnosis any x-rays taken.

- **DENTAL PROPHYLAXIS (CLEANING)** A routine dental prophylaxis involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. This also includes fluoride application, sealants and oral hygiene instructions. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature the office should be contacted.

- **PERIODONTAL TREATMENT** Periodontal disease is an infection causing gum inflammation and/or bone loss that can lead to tooth loss. At times when a routine cleaning is schedule the dental hygienist and dentist may discover periodontal disease is present in all or certain areas of your mouth. If you present with an infection during your routine cleaning appointment it may be necessary for more extensive treatment to be performed. The dental hygienist will stop the routine cleaning and explain to your alternative treatment plans including nonsurgical cleaning below the gum line, placement of an antibiotic below the gum line or a gross debridement (two-part cleaning). If further treatment such as gum surgery and/or extractions are necessary, a comprehensive periodontal exam will be scheduled with our periodontist. The success of any periodontal treatment depends in part on your efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow any other recommendations. Some bleeding after deep cleanings or scaling under the gum line can occur, however, should it persist and if it is severe in nature the office should be contacted. Untreated periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

• **RESTORATIONS (FILLINGS)** A more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure that can only be found during preparation of the tooth. This may lead to root canal, crown or both. Sensitivity is a common aftereffect of a newly placed filling. Occasionally after receiving a filling it may feel high and you may need to return to have the bite adjusted.

• **CROWNS, BRIDGES** It is not always possible to match the color of natural teeth exactly with artificial teeth. A temporary crown will be made after the initial preparation appointment. Temporary crowns may come off and you should be careful chewing on them until the permanent crowns are delivered. If a temporary crown should fall off call the office immediately. The final opportunity to make changes on crowns, bridges (including shape, fit, size, placement and color) will be done before permanent cementation. In some cases, crowns and bridges procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. After a crown or bridge is permanently cemented sometimes your bite may feel high and you may need to return to have the bite adjusted or fixed. Modification of daily cleaning procedures may be required and if so will be explained to you by your provider.

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.

Allergies/Medication
I have informed the dentist of any known allergies I may have. I understand that antibiotics, analgesics and other medications including Nitrous Oxide can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased using alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Consent
This is to certify that I have read the above information form titled "General Dental Procedures". I authorize and consent to having routine dental treatment as listed above performed on me or my child at the Putnam County Dental Clinic.

Printed name of patient: ____

Signature of patient/parent/guardian: ____________________________________

Date: ______________

FDOH – PUTNAM COUNTY DENTISTRY CLINIC
BROKEN APPOINTMETS
All Clients or Parent/Guardians Must Read & Sign

Florida Department of Health Putnam County Dental Clinic strives to improve the oral health of our clients through effective appointment management. Below is very important information regarding your appointment(s).

- A "**BROKEN**" Appointment – Means the *client fails to show up* to a scheduled appointment on time & failed to give 24-HOURS *advance* notice of cancellation prior to time of scheduled appointment. You may call the clinic at 386.326.3336 during business hours (8:00-5:00pm) or leave a message after hours to reschedule appointments.

Putnam CHD value's the limited time we can offer our clients for appointments. Broken appointment hinders our mission to serve as many clients as we can for important preventative and restorative dental care. We are concerned that broken appointments result in delayed dental care for our clients, which is ***NOT*** something we want to occur. It is our hope there will be no broken appointments so the limited appointments we do have available can serve clients waiting and needing dental care. All broken appointments will be noted in your patient record.

- *There are shared* ***consequences*** *for broken appointments:*

  - If a client has ***two broken appointments within a year,*** there will be a ***six-month waiting period*** to be eligible for dental care in our facility

  - If a client has ***three broken appointments within a year,*** there will be a ***one year waiting period*** to be eligible for dental care in our facility

  - If a client is more than 15 minutes late, their appointment may be forfeited and it can be considered a "broken appointment." Please arrive 15 minutes prior to your scheduled appointment time.

- Please ensure we have correct contact and alternate contact information for calling, emailing and texting (if available at dental office) on file. It is ultimately the clients (or parent/guardians) responsibility to keep appointments. Efforts by dental staff will be made to remind patients the day before their appointments.

- Please ensure we have the information and authorizations on file if there are alternate contacts or authorized persons to be called or accompany the client(s) at their appointments.

****

Patient, Parent/Guardian Statement: I have read and understand the above Appointment Guidelines and will provide up-to-date contact information so I can be contacted for reminder and confirmation calls.

Printed name of clients or parent/guardian: ______________________________

Signature of client or parent/guardian: ______________________________

Updated: 11/13/2018