State of Florida
Department of Health

Notice of Privacy Practices Acknowledgment Form

Name: _____ **Client ID#** _____

Facility/Site/Program: _____

I have received a copy of the DOH Notice of Privacy Practices 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 acknowledgment 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 acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on _____
date

___ Face to face meeting
___ Mailing
___ Email
___ Other _____

Reason Individual or 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., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have 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.

Florida HEALTH
Putnam County

NAME: _____
DATE OF BIRTH: _____
ID NUMBER: _____

DENTAL HEALTH HISTORY

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 care of a physician (Doctor)? Yes No
   If yes, list name of doctor: _____
3. Have you (PATIENT) been hospitalized in the last (2) two 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 ever experienced any ill effects from a local anesthetic (Novocain), Penicillin, or any drugs/pills? (ie: Rash, itching or fainting.) Yes No
   If yes, describe: _____
6. Have you (PATIENT) ever experienced any unfavorable reaction from previous dental treatments? 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 to Patient:** _____

Comments by Dentist:

_____
_____
_____

Signature of Dentist _____ Date: _____

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: _____

TODAY'S DATE: _____

DO YOU HAVE AN APPOINTMENT: YES / NO

INITIAL VISIT

PATIENT NAME:_____ DATE OF BIRTH: _____

PATIENT SOCIAL SECURITY NUMBER:_____-_____-_____ RACE: _____ HISPANIC: YES / NO

ADDRESS: _____

MAILING ADDRESS:_____

HOME PHONE #:_____CELL PHONE #:_____OTHER PHONE #:_____

CURRENT SCHOOL:_____

MEDICAID ID NUMBER: _____

PARENT/GUARDIAN NAME: _____ RELATIONSHIP TO PATIENT:_____

WHEN WAS 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

Office Use Only: Check in Time: _____ Chart Number: _____

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: _Florida Department of Health-Putnam County-Dental Clinic

Agency Address: _2801 Kennedy St. Palatka FL 32177

I consent to entering 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.

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.

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

_____ _____

Witness (optional) | Date

Client Name: _____

ID#: _____

DOB: _____

Original to file; Copy to client

DH 3204-SSG-09-2019

Client Name _____ Date_____

You are currently enrolled in _____. Florida Department of Health in Putnam County is not a participating network provider for your managed care plan or TPL.

Florida Department of Health in Putnam County has requested a prior authorization to provide services on date of service _____. We will be billing your insurance company in the event _____ insurance company denies the authorization, you will be responsible for fees for service. If you select to pay for services, your cost for services will be_____ based on the sliding fee scale of _____%.

Your member handbook states you are liable for "the cost of such unauthorized use of covered services from non-participating providers".

You have the choice of:

Cancelling the appointment

Obtaining a prior authorization from your plan which includes the reimbursement rate

Paying for the services.

If you select to pay for the services, your cost for the service is _____

Client signature_____ Date_____

Parent's signature_____ Date_____