DEMOGRAPHIC INFORMATION FORM TO BE COMPLETED BT PATIENT (18 years & older or UIP)

Date of Visit _____ Reason for Visit _____

Legal Last Name _____ Legal 1st Name _____ MI ____

DOB _____ Sex at Birth _____ Race (e.g. Asian/ Black/ Japanese/ White) _____

Language (e.g. English/Arabic/French/Spanish) _____ Hispanic - Yes ☐ No ☐

Marital Status - Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower ☐

Birth Status - Single ☐ Twin ☐ Triplet ☐ Quad ☐ Birth Order (if twin, triplet, etc.) 1st ☐ 2nd ☐ 3rd ☐ 4th ☐

Social Security # _____ Communication Preference (mail, email, cell phone, etc.)_____

Email Address _____ May we contact you via email? Yes ☐ No ☐

Home Address _____ Apt # _____ City _____ ZIP _____

Mailing Address _____ Apt # _____ City _____ ZIP _____

County _____ Home # _____ Cell # _____ Best time to call (morning, evening, etc.) _____

Emergency Contact Name _____ Relationship _____ Phone # _____

Are you covered by Medicaid/ Medicare? Yes ☐ No ☐ Medicaid/ Medicare Number _____/_____

Do you have Health Insurance? Yes ☐ No ☐ INS. Name/Policy # _____/_____

Highest Level of Education _____ Migrant Worker - Yes ☐ No ☐ Seasonal Agricultural Worker - Yes ☐ No ☐ Veteran - Yes ☐ No ☐

Country of Birth _____ Was client born in U.S or born abroad to a parent who was a U.S citizen? - Yes ☐ No ☐

Date Arrived in US _____ Immigration Status (Immigrant, Student Visa, Refugee, etc.): _____ Alien Number: _____

Did you live outside the US for more than 2 months? Yes ☐ No ☐ Country lived in for more than 2 months _____

Employer _____ Work # _____ Gross Income Mo _____

Please list all family members living in your home and note monthly income if applicable

(Income includes all earnings from jobs, pensions, child support, social security, death benefit, alimony, unemployment/worker's compensation, veteran benefits, investments, trust funds, rental income, self-employment, Public Assistance, grants or any other income received.)

Name	Date of Birth	SS#	Relationship	Monthly Income

Do you live in? (check all that apply)

STABLE PERMANENT HOUSING - OWN ☐ RENT ☐ / SUBSIDIZED ☐ UNSUBSIDIZED ☐ / OTHER ☐

TEMPORARY HOUSING/UNSTABLE - HOMELESS ☐ HOUSING SUBSIDY (I.E. Ryan White) ☐ FAMILY/FRIEND ☐ PRISON ☐ JAIL ☐ OTHER ☐

Do you have ...? (check all that apply)

REFRIGERATOR ☐ FAN ☐ WATER INSIDE FOR BATHING ☐ STOVE ☐ INDOOR TOILET ☐ HOT PLATE ☐ WATER INSIDE FOR DRINKING ☐

# of rooms (bedroom/bathrooms/kitchen, etc.)? ____ **Method to heat/cool?** (Central/Window Units/Portable Heater/None) _____/_____

I affirm the information I am providing is true and correct to the best of my knowledge. I understand if I provide false or inaccurate information services may be discontinued and I may have to pay for all services received per the appropriate fee schedule. FACS64f10.003 (5).

Signature _____ **Date** _____

Revised 7/27/17 RLH

ALACHUA COUNTY HEALTH DEPARTMENT CLIENT RESPONSIBLITIES

1. You are responsible for treating all staff and other clients with respect and consideration.
2. You are responsible for answering all questions regarding program eligibility and medical history, etc., completely and correctly to the best of your knowledge.
3. You are responsible for keeping your appointments and obtaining the phone number to call in advance if you have to cancel the appointment.
4. You are responsible for paying all bills when service is provided, unless other arrangements have been made.
5. You are responsible for obeying rules and regulations as posted by the Health Unit or explained by the staff. Some of these rules are:
    A. Monitor and control the behavior of your children while at the clinic.
    B. No food or drink allowed in clinic.
    C. Dispose of garbage in appropriate containers.
6. If you have Medicaid, you must bring your Medicaid card with you to clinic appointments.
7. If you are referred for special care, emergency room, or for hospitalization for a higher level of care, you will be responsible for payment of any services such rendered.

I understand if I miss more than three (3) scheduled medical appointments in a six month period or do not provide 24 hour notice of cancellation of an appointment more than three (3) times in a six month period, I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand if I miss more than two (2) scheduled DENTAL medical appointments in a six month period or do not provide 24 hour notice of cancellation of an appointment more than two (2) times in a six month period, I may lose routine dental care services for six (6) months, though emergency services will still be provided.

I understand that either the Health Care Program I am enrolled in or my Health Insurance Carrier may require me or my child to have a Physical Exam yearly if we receive primary care services. If I decline these services or fail to fulfill this requirement for myself or my child, I understand I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand if I am disruptive or treat clients or staff of the Alachua County Health Department without respect and consideration, I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand if I do not receive medical services from the Alachua County Health Department for a period greater than fifteen (15) months, I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand if I have an insurance coverage change or my insurance lapses, I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand if the Alachua County Health Department has a change in primary care funding, I may be disenrolled from primary care medical services provided by the Alachua County Health Department.

I understand I have the right to appeal a disenrollment decision within thirty (30) days of receiving a 'Termination of Services' notice from the Alachua County Health Department. I must send a written request to have my case reviewed to:

Alachua County Health Department
Attention: Administrator
224 SE 24th Street
Gainesville, Florida 32641

I understand I have the right to file a grievance within thirty (30) days of the date the grievance occurred. I must send a written request to have my grievance reviewed to:

Alachua County Health Department
Attention: Administrator
224 SE 24th Street
Gainesville, Florida 32641

Client Signature: _____ Date: _____

Witness: _____ Date: _____

ACHD Revised 3/7/16 rlh

Place Label Here

Alachua County Health Department

CLIENT'S BILL OF RIGHTS

1. Clients have the right to healthcare that is accessible and meets professional standards.
2. Clients have the right to courteous and individualized healthcare that is equitable, humane, and given without discrimination as to race, color, creed, sex, national origin, source of payment, or ethical or political beliefs.
3. Clients have the right to information about their diagnosis, prognosis, and treatment – including alternatives to care and risks involved – in terms they and their families can readily understand, so that they can give their informed consent.
4. Clients have the legal right to informed participation in all decisions concerning their healthcare and the right to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of their actions.
5. Clients have the right to information about the qualifications, names, and titles of personnel responsible for providing their healthcare.
6. Clients have the right to refuse observation by those not directly involved in their care.
7. Clients have the right to privacy during interview, examination, and treatment.
8. Clients have the right to privacy in communicating and visiting with staff.
9. Clients have the right to refuse treatments, medication, or participation in research and experimentation, without punitive action being taken against them.
10. Clients have the right to coordination and continuity of healthcare.
11. Clients have the right to appropriate instruction or education from healthcare personnel so that they can achieve an optimal level of wellness and an understanding of their basic health needs.
12. Clients have the right to confidentiality of all records (except as otherwise provided for by law or third-party payer contracts) and all communication, written or oral, between clients and healthcare providers.
13. Clients have the right to examine and receive an explanation of his/her bill regardless of source of payment.
14. The client has the right to know what rules and regulations apply to his conduct as a client.

Client Signature: _____ Date: _____

Witness: _____

ACHD Revised 5/26/15

Place Label Here

INITIATION OF SERVICES

PART I. CLIENT – PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: Dental Clinic - Alachua County Health Department

Agency Address: _____

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representative 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 test 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 healthcare operations.

PART III. COMMUNICATIONS

I understand the Florida Department of Health (DOH) uses a patient portal to communicate with me about my healthcare. 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 user name 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 assigned 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

1._____ WITHDRAWAL THIS CONSENT. Effective_____

Client/Representative Signature Date

_____ _____

Witness (optional) Date

Client Name: _____

ID#:_____

DOB: _____

Original to file; Copy to client

DH8001-IT-01/2017

Alachua Dept Of Health

Eaglesoft 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, c

Are you under a physician'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?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other? ☐ 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	Osteoporosis ◯ 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

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

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____