PLEASE PRINT

Date _____ Nickname _____

Patient's Name _____ Race _____ Sex _____ Age _____

D. O. B. _____ Address _____ City _____

Zip _____ School _____ Grade _____

Phone #1 _____ Phone #2 _____

Parent/Guardian _____
(PLEASE PRINT NAME)

PLEASE GIVE THE DENTAL CLINIC 2 CONTACT NUMBERS – THANKS!

Dental Health History

Name _____
ID No. _____
Birthdate _____

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

LATEX ALLERGIC YES/NO

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 Tranfusions	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 years? Yes No
   If yes, why? _____

4. Are you (**PATIENT**) currently taking any medication, 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? i.e., rash, itching or fainting. If yes, describe. _____ Yes No

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

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 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 _____

SANTA ROSA COUNTY HEALTH DEPARTMENT
DENTAL CLINIC APPOINTMENT POLICY

The dental staff of the Santa Rosa County Health Department considers it a privilege to provide dental services for the clients deemed eligible in Santa Rosa County.

It is also a privilege for the clients to have an opportunity to receive dental care at no charge through the Santa Rosa County Health Department.

For this relationship to be mutually beneficial:

1. The dental staff must respect our clients through disclosure of clinical findings, discussion of treatment options, and delivery of excellent dental care in a friendly, courteous environment.

2. The clients must follow treatment objectives, practice proper nutrition and home care, and keep scheduled appointments.

3. Clients must cooperate with the dental staff during treatment.

4. Parents are not allowed in the operatory rooms during a procedure as this is a sterile environment and must be maintained as such. If a problem arises, you will be notified immediately by the dentist, hygienist, or dental assistant.

5. Clients need to schedule their next restorative appointment each visit until all restorative requirements are completed.

6. Clients need to maintain current contact information with the dental clinic, such as cell and home telephone numbers, mailing address, etc.

In order to meet scheduling objectives, we ask clients to arrive at least five (5) minutes early for their dental appointment. We also ask that clients brush their teeth immediately prior to arriving for an appointment, or bring their toothbrush and allow time to brush before their appointment.

We understand unforeseen problems arise (sickness, school events, transportation, etc.), which could prevent a person from keeping their scheduled dental appointment, and we will make allowances for an "occasional" unforeseen event resulting in a missed appointment. However, when possible, we do ask that you give us 24 hours notice if you cannot make an appointment.
In the event a client arrives over fifteen (15) minutes late or does not come in at all, it will be classified as a "broken appointment". If a client breaks their appointment, and then comes in later, we will make an effort to provide treatment that day, but priority will be given to other clients who arrive on time for their scheduled appointments.

If a client breaks three (3) appointments in a twelve (12) month period of time, she/he will be considered to have abused the privilege to receive dental services at Santa Rosa County Health Department and will be dismissed as a dental patient.

"Dismissal" means that your child's services will be reduced to emergency care only. They will no longer be eligible to receive preventive or restorative care such as cleanings, fillings, sealants, etc. They will only be treated for their current emergency and will be seen on a sit & wait basis between scheduled appointments. It is important to remember that, if a client provides at least 24 hours advance notice, it is not considered a broken appointment and does not count toward the three (3) that lead to dismissal.
I have read and agree to abide by this policy.

_____	_____	_____
Child's Name	Parent's Signature	Date

GENERAL DENTISTRY FOR CHILDREN

Dear Parent,

Welcome to the Santa Rosa County Dental Clinic. We are a "general dentistry" practice, currently only seeing children from age 4 until their 21st birthday. For many of our clients, this may very well be their first trip to a dental office. We will be evaluating each child to see if they are able to be treated in a "general dentistry" practice such as ours, or if they will need services that are more specialized.

A "specialized dentistry" practice uses sedation, including laughing gas or sedative drugs, and/or restraint, which usually includes placing the patient on a board called a papoose board so the child cannot move and thereby injure themselves during treatment. Please understand that restraint is used for the patient's protection and is not the parent, the dental staff, or the dentist trying to hold the patient still to perform treatment.

As stated previously, we are a "general dentistry" practice, so we do not use any type of sedation or restraint with our clients. If behavior management becomes an issue during dental treatment, we will most likely refer the child out for "specialized dentistry". We always try very hard to work with children so this does not happen, but unfortunately some children refuse to receive treatment or will not respond to verbal instructions.

We look forward to a happy and healthy relationship with your child so they can receive the best dental services available. Please let us know how we are doing and if you have any questions, feel free to ask at any time. Thank you.

Dr. Thomas H. Pyritz
Senior Dentist
Santa Rosa County
Health Department
(850) 983-5210

Please sign and date that you have read and understand we are a General Dentistry Practice only.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

FLORIDA DEPARTMENT OF HEALTH

INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: Santa Rosa County Health Department

Agency Address: 5527 Stewart St, Milton FL or 5840 Gulf Breeze Parkway, Gulf Breeze FL or 215 Alabama St. Jay FL

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, 11/08

Original to file Copy to client