PANCARE OF FLORIDA, INC.

MOBILE UNIT INTAKE FORM

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Social Security Number | **Date of Birth** | **U.S. Military Service (☑ one):** ☐ None ☐ Currently Serving ☐ Discharged

Address | **City** | **State** | **Zip Code** | **County**

Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )	**Email**

Marital Status (☑ one): ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Primary Language Spoken: ☐ Limited English

Patient's Relationship to Responsible Party (☑ one): ☐ Self ☐ Spouse ☐ Natural Child ☐ Parent ☐ Foster Child ☐ Foster Parent

Gender (☑ one): ☐ Female ☐ Male ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐ Choose Not To Disclose

Sexual Orientation (☑ one): ☐ Choose Not To Disclose ☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something Else ☐ Don't Know

Race (☑ one): ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native ☐ White

Ethnicity (☑ one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Are you a migrant/seasonal worker or a family member of a migrant/seasonal worker? ☐ Yes ☐ No

What is your annual income? ☐ $1-$27,000 ☐ $27,001-$33,000 ☐ $33,001-$40,000 ☐ $40,001+ ☐ No Income

How many people (including you) does your income support? _____

Which describes your housing situation? ☐ Own/Rent ☐ Public Housing ☐ Homeless

Emergency Contact	**Phone** ( )	**Relationship to Patient**

RESPONSIBLE PARTY INFORMATION (enter name of person *FINANCIALLY* responsible for your account)

Last Name | **First Name** | **Middle Initial**

Mailing Address | **City** | **State** | **Zip Code** | **County**

Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )	**Date of Birth**	**Social Security Number**

INSURANCE COMPANY – *INCLUDING MEDICAID*

Primary Insurance | **ID#** | **Group #** | **Insurance Company Address**

Name of Insured | **Date of Birth** | **Insured's Employer**

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Natural Child ☐ Step Child Parent ☐ Foster Child ☐ Foster Parent

Secondary Insurance | **ID#** | **Group #** | **Insurance Company Address**

Name of Insured | **Date of Birth** | **Insured's Employer**

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Natural Child ☐ Step Child Parent ☐ Foster Child ☐ Foster Parent

Assignment and Release: *I authorize my insurance benefits to be paid directly to PanCare Health. I also authorize PanCare Health to release any information required to process this claim.*

SIGNATURE: _____ **DATE:** _____

Patient Name:_____ Birth Date:_____
Last First MI

HEALTH HISTORY

Reason for Today's Visit:_____

Check ☑ all that apply to you

	ADHD		Coughing Up Blood		Heart Attack		Radiation
	Alcohol Use		Dark or Black Stools		Heart Catheterization		Rectal Bleeding
	Anemia		Depression		Heart Disease		Rheumatoid Arthritis
	Anxiety		Diabetes		Heart Murmur/Irregular Beat		Seizures
	Artificial Joints		Diarrhea		Hepatitis A, B, or C		Sexual Difficulties
	Asthma		Dizziness		High Blood Pressure		Shortness of Breath
	Autism		Drug Addictions		HIV/AIDS (Risk or Exposure)		Sickle Cell Anemia
	Blood in Stools/Urine		Earache		Jaundice		Sleep Difficulties
	Blood Disease		Emphysema		Kidney Disease/Stones		Smoker
	Blood Transfusion		Epilepsy		Liver Disease		Street Drug Use
	Bowel Changes		Excessive Bleeding		Marital Problems		STDs
	Cancer		Fainting		Mental Health Disorder		Stroke
	Changing Moles		Fractures		Osteoarthritis		Suicide Attempt
	Chest Pain		Gallbladder Disease		Pacemaker		Thyroid Disease/Problems
	Cholesterol (high)		Gout		Pneumonia		Tobacco Use
	Chronic Cough		Hay Fever		Pregnant – Due Date:		Tuberculosis (TB)
	Constipation		Head Injury		Prostate Problems		Wheezing

Last Pap Smear:_____
Last Mammogram:_____
Number of Pregnancies:_____

Number of Births:_____
Birth Control Method: ☐None ☐Pill ☐Condoms ☐IUD
☐Shots ☐Tubal ☐Vasectomy ☐Other _____

Allergies:_____

Medications:_____

_____

Pharmacy Name and Location:_____

Hospitalization/Surgeries:_____

Dental Pain □ Yes □ No, If yes, explain:_____

FAMILY HISTORY

Check ☑ all that apply to you and your family

	Alcohol Abuse		Cancer		Diabetes		Heart Disease
	Asthma		Depression		Glaucoma		High Blood Pressure

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Patient, Parent, or Guardian Signature Date

_____ _____
Dental Provider Signature Date

_____ _____
Medical Provider Signature Date

Patient Name:_____ Birth Date:_____
Last First MI

Initials_____Notice of Privacy Practices/Patient Rights and Responsibilities

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this organization's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I also understand that the Patient Rights and Responsibilities are available for my review and that I have responsibilities regarding my care.

I understand that:

- I have the right to review this organization's Notice of Privacy Practices prior to signing this acknowledgement;
- I have the right to review the Patient Rights and Responsibilities prior to signing this acknowledgement;
- This organization reserves the right to change these documents and that these documents are available to me upon request at my next visit, and on the organizations web site: www.pancarefl.org.

Initials_____Consent for Treatment

I hereby authorize PanCare Health, its facilities and treatment centers, its affiliated physicians, dentists, ARNPs, physician assistants and other medical personnel to administer examinations and treatments as deemed medically necessary.

Initials_____Release of Medical/Dental Information

It is the provider's responsibility to ensure that the provider-patient relationship is confidential. Under the requirements of the Health Insurance Portability and Accountability Act (HIPAA), we are not allowed to release any patient information without the patient's consent. If you wish to have your medical/dental or billing information released to a family member, friend, or legal representative, you must sign this form. Signing this form will give consent to release this information to only the persons indicated below. This consent form will not allow PanCare Health to release any other information to these persons. You have the right to revoke this consent in writing.

I authorize/allow PanCare Health to release my medical/dental and/or billing information to the following individual(s):

NAME	RELATIONSHIP TO PATIENT

Acknowledgement

I have initialed the Notice of Privacy Practices/Patient Rights and Responsibilities and Consent for Treatment. By doing so I acknowledge that I have read all of the aforementioned statements and will abide by the same and if I do not this may disqualify me from receiving care from PanCare Health/Dental Clinic.

_____ _____
Signature of Patient/Legal Representative Date

_____
Printed Name of Patient/Legal Representative