



Payment Information for Dental Services



707 Jenks Ave., Panama City, Florida 32401 (850) 767-3350 / FAX: (850) 747-5274
 479 East Highway 20, Freeport, Florida 32439 (850) 880-6568 / FAX: (850) 880-6583

PATIENT INFORMATION				
Last Name		First Name		Middle Initial
Social Security Number		Date of Birth		U.S. Military Service (<input checked="" type="checkbox"/> one): <input type="checkbox"/> None <input type="checkbox"/> Currently Serving <input type="checkbox"/> Discharged
Address		City	State	Zip Code County
Home Phone ()	Work Phone ()	Cell Phone ()		Sex <input checked="" type="checkbox"/> : <input type="checkbox"/> F <input type="checkbox"/> M
Marital Status (<input checked="" type="checkbox"/> one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		Primary Language Spoken:		Patient's relationship to responsible party (<input checked="" type="checkbox"/> one) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent
Please answer both questions. 1. RACE <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Latino <input type="checkbox"/> Asian Pacific Islander <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Undocumented 2. ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic				
Emergency Contact			Phone ()	Relationship to Patient
RESPONSIBLE PARTY INFORMATION (enter name of person FINANCIALLY responsible for your account)				
Last Name		First Name		Middle Initial
Street Address		City	State	Zip Code County
Mailing Address		City	State	Zip Code County
Home Phone ()	Work Phone ()	Income: \$_____ PER: <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Month <input type="checkbox"/> Year		
Employer Name		Employer Address		
Social Security Number		Birth Date		Sex <input type="checkbox"/> F <input type="checkbox"/> M Marital Status (one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
INSURANCE COMPANY				
Primary Insurance		ID#	Group #	Insurance Company Address
Name of Insured		Date of Birth		Insured's Employer
Relationship to Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Step Child Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent				
Secondary Insurance		ID#	Group #	Insurance Company Address
Name of Insured		Date of Birth		Insured's Employer
Relationship to Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Step Child Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent				
Assignment and Release: I authorize my insurance benefits to be paid directly to the Community Health Center Dental Clinic. I also authorize the Community Health Center Dental Clinic to release any information required to process this claim.				
SIGNED: X _____ DATE: _____				

Patient Health Information



Community Health Center **Dental Clinic**, 707 Jenks Ave., Panama City, Florida 32401 (850) 767-3350
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Patient Information

Patient Name: _____ Today's Date: _____
Last First MI
Social Security Number: _____ Birth Date: _____
Home Phone: _____ Cell : _____ Work Phone: _____ Ext. _____
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for Visit: _____

Have you ever had any of the following? Check those that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Smoker / Tobacco User |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Thyroid Problems |
| | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Due Date: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

Are you currently having any dental pain or problem? _____

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Are you now under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Are you currently taking any medications, pills or drugs? Yes No

If yes, for what reason: _____

Are you allergic to or have you ever experienced any ill effect from a local anesthetic (Novocain), penicillin, codeine or any drugs ie: rash, itching or fainting?

If yes, describe: _____

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.

Date: _____

Signature of patient, parent or guardian

Date: _____

Doctor's Signature

Notice of Privacy Practices



Community Health Center **Dental Clinic**, 707 Jenks Ave., Panama City, Florida 32401 (850) 767-3350
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Our Notice of Practice Policies provides a description of our treatment, payment activities and healthcare operation. It also contains uses and disclosures we may make of your protected health information. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices at any time. If we do so, we will issue a revised notice of privacy practices.

Purposes: This form is used to obtain acknowledgment that you have been notified that our NOTICE OF PRACTICE POLICIES can be obtained via our office. (Community Health Center, 707 Jenks Ave., Panama City, FL 32401 or 479 East Hwy. 20, Freeport, FL 32439) This document is printable via the website for your records. HIPPA website: <http://www.hhs.gov/ocr/hipaa/finalreg.html>

By signing this section, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

You have the right to revoke this consent at anytime by giving us a written revocation.

Signature

Date

Consent to Obtain Protected Health Information



Patient's Name: _____ Date of Birth: _____

I give my permission for _____ to release all protected health information

Healthcare Provider/Facility

to Community Health Center for the purpose of treatment. This includes general medical reports, history and physicals, progress notes, diagnostic test reports, immunizations, prenatal records, consultations and any other information necessary for the purposes of treatment. This release includes information relating to STD's, HIV/AIDS, TB, Drug/Alcohol, Mental Health, WIC Eligibility & Early Intervention.

Health Care Provider/Facility: _____

Address: _____

Phone: _____ Fax: _____

Signature

Relationship to Patient

Date

Consent for Dental Treatment



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I hereby give my consent for dental treatment or dental surgery to be performed, the routine treatment to consist of restoring decayed or broken teeth, extracting non restorable pathologically involved or mal- positioned teeth, replacing missing teeth with prosthetic appliances, treating oral infection, pathological conditions and abnormalities by mechanical and/or chemical means. I hereby request and authorize all necessary dental treatments be performed by the Community Health Center, Dental Clinic, and authorize the use of such anesthetics and medications as necessary to accomplish the dental treatment.

I understand that if I am the parent of a minor (under the age of 18) that is receiving treatment in the dental clinic, I will remain in the waiting area unless I am asked to come to the treatment operatory by the provider.

I also give my consent for the dentist to contact my parents(s), spouse, guardian(s), or relatives to obtain written consent to render any dental treatment required.

Signature of Patient: _____ Date: _____

Relationship to Patient: _____ Date: _____

Witness Signature: _____

Broken Appointment Policy Agreement



It is the responsibility of the patient (or the parent, in the case of a child) to notify the dental staff any time they will not be available for their appointment, at least 24 hours prior to the scheduled appointment time. When scheduling two or more patients per family, 48 hours will be required prior to the cancellation of the scheduled appointment.

Every effort will be made to contact patients the day before their scheduled appointment to remind them of the time and provide any instructions prior to the appointment. The dental staff will make every effort to work with the patient to reschedule the appointment as soon as possible if necessary.

When the staff is expecting a patient, they routinely prepare the operatory, instruments and supplies for that patient's treatment. When the patient does not show up, it results in wasted staff time, supplies, and time that could have been used for other patients. Therefore, patients who break two appointments will no longer be seen at our clinics, along with any siblings living in the same residence, or any adult responsible for that child's dental treatment for one year from the date of their second broken appointment.

I have read and understand the above statement. By signing below, I acknowledge that I will make every effort to notify the dental staff at least 24 hours in advance if I will not be able to make my scheduled appointment. I also understand that if I or a family member breaks two appointments without notice, we will not be scheduled for further services for one year from the date of last broken appointments.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Sliding Fee Application Form



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Complete the Following

I, _____, am requesting to be considered for the sliding fee scale discount offered by PanCare of Florida, Inc. By filling out this form **and attaching my current tax return** and returning it for processing, I am asserting that the facts contained within are true and correct to the best of my knowledge.

Signed: _____

Date: _____

Current Income:

Employer: _____

Employer's Phone Number: _____

Monthly Income: _____

Spouse/Significant Other's Employer: _____

Monthly Income: _____

Any Other Income: _____

List Everyone Living in Your Household:

Last Name, First Name	Social Security Number	Date of Birth	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I have attached:

- A copy of my CURRENT TAX RETURN.**
- A copy of a pay stub for the last month for me and my spouse/significant other.

NOTE: Your fee for seeing the dentist is based on the information you have provided on this page and reinforced with proof of income you have attached. Our services are not free, and you will be charged a fee upon arrival to each of your appointments.