Volusia County Health Department Dental Clinic
INFORMED CONSENT FOR DENTAL TREATMENT
CONSENTIMIENTO INFORMADO PARA EL TRATAMIENTO DENTAL

NATURAL / ADOPTIVE PARENT GUARDIAN SELF (PLEASE CIRCLE ONE)

I authorize the following treatment procedures. (Please initial by each procedure)
Yo autorizo los siguientes tratamientos. (Por favor marquee sus iniciales en cada linea de procedimiento)

_____Exam _____*Examen*	_____X-Ray _____*Rayos-X*	_____Notarized Form Accepted _____*Forma Notariada Aceptada*
_____Dental Cleaning _____*Limpieza Dental*	_____Fluoride Treatment _____*Tratamiento de Fluoruro*	_____Notarized Form Declined _____*Forma Notariada Declino*

_____ _____
Patient or Legal Guardian Signature — Date
Firma del paciente o guardian legal — *Fecha*

_____ _____
Dentist Signature — Date
Firma de dentista — Fecha

The following treatment plan, benefits, alternative treatments, and significant risk factors associated with this treatment have been explained to my satisfaction.

El siguiente plan de tratamiento, beneficios, tratamientos alterno, y factores significativos asociados con este tratamiento han sido explicados a mi major entendimiento.

_____Preventive Sealant _____*Sellantes Preventivos*	_____Dental Filling(s) _____*Relleno o empaste*
_____Extraction _____*Extracciones*	_____Local or Topical Anesthesia _____*Anestecia local o superficial*
_____Pulpotomy _____*Pulpotomia*	_____Other: _____*Otro:*

_____ _____
Patient or Legal Guardian Signature — Date
Firma del paciente o guardian legal — *Fecha*

_____ _____
Dentist Signature — Date
Firma de dentista — Fecha

PATIENT HEALTH HISTORY

Indicate below any of the following which you presently have or have had in the past. Indique Si Tiene o ha tenido en el pasado alguna de las siguientes enfermedades.

Yes / Si	No	
( )	( )	Latex allergies / Alergias al latex
( )	( )	Asthma / Asma
( )	( )	Heart murmur / Soplo en el corazón
( )	( )	Rheumatic fever / Fiebre Reumática
( )	( )	High blood pressure / Presión alta
( )	( )	Sickle cell anemia / Celulas de Anemia
( )	( )	Diabetes / Diabetes
( )	( )	ADD or Hyperactivity / ADD o Hiperactividad
( )	( )	Emotional problems / Problemas emocionales
( )	( )	Epilepsy or Seizures / Epilepsia
( )	( )	Pain in jaw joints / Dolor en la articulación de la mandíbula
( )	( )	Autism/Autism
( )	( )	Congenital heart lesions / Lesiones congénitas en el corazón
( )	( )	Heart disease or attack / Enfermedad o ataque del corazón
( )	( )	Angina pectoris / Angina de pecho
( )	( )	Artificial heart valve / Válvulas artificiales en el corazón
( )	( )	Heart pacemaker / Marcapaso
( )	( )	Heart surgery / Cirugia del Corazón
( )	( )	Anemia or Blood problems / Anemia o Problemas con la Sangre
( )	( )	Dialysis – Kidney (disease) / Diálisis – enfermedad del riñon
( )	( )	Artificial joints / Huesos artificiales
( )	( )	Glaucoma / Glaucoma
( )	( )	Cold sores – Fever blisters / Ulceras en la boca – por fiebre
( )	( )	Sinus trouble / Problemas de sinusitis
( )	( )	Thyroid disease / Enfermedad de la tiroide
( )	( )	HIV-AIDS / HIV-SIDA
( )	( )	Hepatitis A, Hepatitis B, Hepatitis C / epatitis A, Hepatitis B, Hepatitis C
( )	( )	Liver disease / Enfermedad del higado
( )	( )	Blood transfusion / Transfusiones de sangre
( )	( )	Hemophilia / Hemofilia
( )	( )	Syphilis, Gonorrhea, Herpes / Sifilis, Gonorrea, Herpes
( )	( )	Fainting or Dizziness / Desmayos o Mareos
( )	( )	Stroke / Derrame Cerebral
( )	( )	Cancer / Cancer
( )	( )	Shunt / Drenaje

Please list below any disease or problem not listed above. Por favor, detallar otra condición o enfermedad, sí alguna.

Please indicate below any medications or drugs you are currently taking. Por favor indicar si esta tomando alguna de las medicinas Indicadas.

Yes / Si	No	
( )	( )	Antibiotics or Sulfa drugs / Antibióticos o Sulfamida
( )	( )	Anticoagulants or Blood thinner / Anticuagulantes o Diluyentes de sangre
( )	( )	Medicine for high blood pressure / Medicina para la presión alta
( )	( )	Cortisone / Cortisona
( )	( )	Tranquilizers / Tranquilizantes
( )	( )	Antihistamines / Antiestaminicos
( )	( )	Asprin / Aspirinas
( )	( )	Insulin or Medicine for diabetes / Insulina o Medicina para diabetes
( )	( )	Digitalis / Digitalina (Diálisis)
( )	( )	Nitroglycerin / Nitroglicerina
( )	( )	Other / Otros

Please indicate if you are allergic to any medications or drugs in the list below. Por favor indicar si es alergico a alguna medina indicadas.

Yes / Si	No	
( )	( )	Local anesthetics / Anestesia local
( )	( )	Penicillin or other antibiotics / Penicilina u otro antibiótico
( )	( )	Asprin / Aspirina
( )	( )	Ibuprofen (Motrin, Advil) / Ibuprofen (Motrin, Advil)
( )	( )	Barbiturates or sedatives / Barbitúrios o sedantes
( )	( )	Codeine or other narcotics / Codeina u otros narcóticos
( )	( )	Other / Otros

Yes / Si	No	
( )	( )	Are you in pain or discomfort at this time? ¿Tiene dolor o molestia en este momento?

Yes / Si	No	
( )	( )	Are you pregnant? / ¿Está usted embarazada? If yes, what is your due date? / ¿Fecha de alumbramiento? _____

I have answered the questions to the best of my knowledge. I have asked for an explanation of any words I do not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

He contestado las preguntas segun mi mejor conocimiento. He preguntado por una explicación de alguna palabra, y mis preguntas han sido contestadas a mi mejor satisfacción. No responsabilizaré al dentista ni al personal dental por algun error u omisión que yo halla hecho al completar esta forma.

_____ _____

Patient or Legal Guardian Signature
Firma del Paciente o Guardian Legal

Date / Fecha

_____ _____

Signature of Dentist / Firma del Dentista

Date / Fecha

VOLUSIA COUNTY HEALTH DEPARTMENT DENTAL OFFICE NEW PATIENT QUESTIONNAIRE - ADULT

Patient Information - Información paciente

Name/Nombre:_____

Birth Date/Fecha de nacimiento: _____

Social Security Number/Numero de Seguro Social: _____

GendeGenero: _____

Primary Language/Lengua primaria: _____

Marital Status/Estado Civil: ☐Single/Soltero ☐Married/Casado ☐Divorced/Divorciado ☐Separated/Seperado ☐Widowed/Viuda

Race/ Raza: *If Multi-Racial, select all that apply/ Si* es *Multi-Racial, seleccione todos* /os *que* se *apliquen*

☐American Indian/Alaskan Native Indio Nativo/de Alaska Americano

☐Japanese/Japones

☐Korean/Coreario

☐Asian Indian/Indio asiatico

☐Pacific Islander (other)/Isleno pacffico (otro)

☐Asian Other/Asiatico otro

☐Black/African-American/ Negro /Africano-Ameri cano

☐Samoan

☐VietnameseNietnamita

☐Chinese/Chino

☐White/Blanca

☐Filipino/Filipino

☐Other/Otro

☐Guamanian

☐Hawaiian Native/Hawaiano

Ethnicity/Pertenencia etnica: ·

☐Hispanic/Latino- Hispano/Latino

☐Non-Hispanic/Latino - Non-Hispano/Latino

☐Unknown/Unreported - Desconocido/no denunciado

Country of Birth/Pais de nacimiento:

If born outside the U.S., date arrived/Si nacido fuera de los Estados Unidos, la fecha llego _____

Page 2 - Patient Information - Información paciente

Street Address/Direccion:_____

Mailing Address/Direccion de envies: _____

Home Telephone Number/Numero de telefono casero: _____

Cell Phone Number/Numero de telefono cellular: _____

Employer/Lugar de empleo: _____

Employer Address/Direccion de empleo: _____

Occupation/Ocupacion: _____

Start Date/Fecha del comienzo: _____ Telephone{ Numero de telefono: _____

Estimated Earned Monthly lncome/Sueldo mensual: $_____

Unearned Monthly Income/ Otros ganancias mensuales: $_____

(Unearned income includes Social Security, Public Assistance, Unemployment, Alimony, Worker's Comp, Child Support, etc. – Otros ganancias incluye Seguro Social, la asistencia publica, el desempleo, los a/imentos, comp def trabajador, ayuda de ninos, otra)

Monthly Expenses/Gastos mensuales

Mortgage/Rent - Hipoteca/alquiler: $_____

Food/Alimento $_____

Utilities/Utilidades $_____

Phone/Telefono $_____

Auto Loan/Prestamo auto $_____

Credit Cards/Tarjetas de credito $_____

Other Loans/Otros prestamos $_____

lnsurance/Seguro $_____

Alimony/Pension $_____

Medical/Medico $_____

Other/Otro $_____

Page 3 - Household Information – Informacion sobre familia

Total Number of Persons in the Household/Numero total de personas en la casa:____________

Name/Nombre	DOB/Fecha de nacimiento	SS#/Número de Seguro Social

INITIATION OF SERVICES

PART I CLIENT - PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: **Volusia County Health Department Dental Clinic**

Agency Address: **1845 Holsonback Dr., Daytona Beach, FL 32117**

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, [Approved November 2008], Original to file Copy to client

DENTAL OFFICE APPOINTMENT POLICY

In agreement with the policies of the Florida Department of Health and the Volusia County Health Department, the following policy was created for the benefit of all clients.

- **Alternating Appointments**. It is necessary that clients are scheduled appointments that alternate between morning and afternoon hours to allow all clients access to morning and afternoon appointments. For example, if your first visit is in the morning, your second will be in the afternoon, third in the morning, etc.

- **Cancelled Appointments**. Appointments must be cancelled at least twenty-four (24) hours in advance. Canceling the same day of an appointment is considered a broken appointment.

- **Broken Appointments ("No Show")**. Clients with two (2) broken appointments in a six (6) month period will be placed on a waiting list. After six (6) months, clients may schedule another appointment. This ensures that clients who do not keep their appointments will not continue to occupy timeslots that could be used by other clients.

- **Adult (Over 21) Broken Appointments ("No Show")**. Clients with one (1) broken appointment or canceling the same day of their appointment will be referred to another dental office for treatment.

- **Arriving Late to Your Appointment**. Clients that arrive more than ten (10) minutes late for their appointment will have to reschedule so that clients that arrive on time may be seen at their scheduled appointment time.

- **Informed Consent**. Only parents and legal guardians may approve the treatment of a client. Clients accompanied by a person who is not a parent or legal guardian will not be treated unless there is a notarized, signed consent for treatment from the parent or legal guardian.

- **Unaccompanied Minor**. Unaccompanied, underage adolescents (up to age 18) will not be seen for treatment.

- **Patients of Record**. No one will be offered dental services without a documented dental record.

Print – Name of Parent or Legal Guardian Date

Signature of Parent or Legal Guardian Name - dental staff

State of Florida

Department of Health

Notice of Privacy Practices Acknowledgement Form, DH 150-741, 09/13

Name _____ **Client ID**:_____

Facility/Site/Program: **Florida Department of Health in Volusia County Dental**

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 acknowledgement 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 acknowledgement 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)_____

_____Mailings_____

_____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.