FRANKLIN SCHOOL K-12
DENTAL CARE AT NO COST!

Dear Parent/Guardian:

PanCare of Florida, Inc./ PanCare Health, Dental Clinic will be providing preventive dental treatment for students at Franklin County School. **The preventive dental treatment done on campus will be at NO cost to parents/guardians.** However, if your child has Medicaid or any other dental insurance it may be billed for dental services rendered on campus.

Initially, dental examinations will be completed. Dental cleanings, fluoride treatments and sealants (protective coating on the chewing surfaces of the back teeth to help protect the teeth against decay) may be completed on the same date or on another date. On the date of treatments parents/guardians will receive written updates of any treatment completed and/or recommended. Your child will not be given any sedatives or other medications. Parents/Guardians do not have to be present when the services are provided, but permission is required.

If you wish for your child **to participate in this program**:

- **Fully complete all forms and promptly return the packet to the teacher.**

___ **YES**, I hereby give consent for my child ________________________________, to be examined by the dentist. I also give consent for my child to receive the preventive treatment recommended. I understand that these services will be provided by PanCare of Florida, Inc./PanCare Health, Dental Clinic, and not by the School District.

___ **NO,** I do not wish for my child to participate.

Child/Patient Name (Printed)	**Child/Patient Date of Birth**	**Child/Patient Gender**
		Male Female
Parent/Guardian Name (Printed)	**Parent/Guardian Signature**	**Date**
If you are the child's guardian, what is your relationship to the child/patient?		

Teacher: ____ **Grade:** ______________________

Important: All forms must be completed and signed before dental services can be provided.

PANCARE OF FLORIDA, INC.

DENTAL INTAKE FORM

PATIENT INFORMATION

Last Name	First Name	Middle Initial

Social Security Number	Date of Birth

Address	City	State	Zip Code	County

Home Phone	Work Phone	Cell Phone	Other Phone

Primary Language Spoken:

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

Gender (X one):
☐ Female ☐ Male

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

Ethnicity (X one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
Are you a migrant worker or a family member of a migrant worker? ☐ Yes ☐ No

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	Other Phone

INSURANCE COMPANY – *INCLUDING MEDICAID*

Primary Insurance	ID#	Group #	Insurance Company Address

Policyholders Name	Date of Birth	Policyholders Social Security #	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:____Today's Date:_______________
Last First MI

Birth Date: ______________________ Social Security Number:____

HEALTH HISTORY

Reason for Today's Visit:____

Check all that apply to you:

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

Last Pap Smear:_______________________________
Last Mammogram:______________________________
Number of Pregnancies:__________________________

Number of Births:________________________________
Birth Control Method: ☐None ☐Pill ☐Condoms ☐IUD
☐Shots ☐Tubal ☐Vasectomy ☐Other________________

Allergies:____

Medications ____

____

Hospitalization/Surgeries:____

____

Dental Pain ☐ Yes ☐ No, If yes, explain:____

____

FAMILY HISTORY

Check all that apply to you/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

____ ______________________
Provider Signature Date

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 or treatment centers, its affiliated physicians, dentists, ARNPs, physician assistans 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 only give consent to release this information to 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