

GENERAL CONSENT FOR TREATMENT AND BILLING

I, the undersigned, give permission for myself or minor child, as indicated above, to undergo all necessary tests, examinations, treatments, or other procedures required by the medical or dental staff for Family Health Centers of Southwest Florida, Inc. (FHCSWF) to diagnose and/or treat illness(es).

I realize that the practice of medicine, surgery, and dentistry is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatments or examinations by FHCSWF.

I consent to the release of my medical and dental information by FHCSWF and/or authorized institutions or agencies accepting the patient for medical, dental, or institutional care. I consent to the release of medical and dental information to patient's insurer. I give permission to release data (medical, dental, and personal) to such government agencies as is required of FHCSWF.

I hereby authorize payment to FHCSWF of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS otherwise payable to me, but not to exceed the health center and/or physician's or dentist's regular charges for this period of treatment.

Family Health Centers is affiliated with various educational facilities. I understand I will be notified by these personnel that they are a student and have the right to refuse to have them involved in my care. I also understand that if they are involved in my care, an employed healthcare professional of Family Health Centers is overseeing all services and care provided.

FHCSWF PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

I acknowledge that a copy of the FHCSWF Patient Bill of Rights and Responsibilities, a mutual agreement between me and FHCSWF, has been made available to me. A printed copy is available upon request.

HIPAA – NOTICE OF FHCSWF PRIVACY PRACTICE

I acknowledge that a copy of the Statement of Patient Privacy Practices, which explains the commitment of FHCSWF to protecting my personal health information in compliance with the law, has been made available to me. A printed copy is available upon request. I do hereby authorize the unrestricted release of my personal health information to the following individuals:

| NAME: | RELATIONSHIP (e.g. – Mother, Sister, Spouse, etc.) |
|-------|--|
| 1. | |
| 2. | |
| 3. | |

| | | | |
|--|--|--|--|
| Total Annual Household Income: \$ | | Total Number of People in Your Household: | |
|--|--|--|--|

| | Yes | No |
|--------------------|-----|----|
| Are you a Veteran? | | |
| Are you disabled? | | |
| Are you homeless? | | |

| | | | |
|--|------------------|-------------|--------|
| If homeless what is your living situation? | Transitional | Street | Other: |
| | Homeless Shelter | Doubling Up | |

Migrant/Seasonal/Other Determination

Answer the following questions regarding you or the guarantor's employment within the past 24 months:

| Worked or are working in: | | Have you or the guarantor moved outside of the country or state to perform your/their job anytime during the year? | |
|---|--|--|-----------------------------|
| 1. the fields tilling soil or picking fruits, vegetables, flowers, sugar cane, etc. | 3. a packinghouse or transporting the items in #1 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. tree farming | 4. a worm farm, shrimp boat, or gathering of other seafood | Do you or the guarantor stay at one permanent address to perform your/their job throughout the year? | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

ADVANCE DIRECTIVES – RIGHT TO DECIDE – END OF LIFE DECISIONS

You cannot remove all uncertainty about your future healthcare needs but, by having Advanced Directive, you can have the peace of mind that comes from making your wishes known in advance. Please make a copy of any Advanced Directives and FHCSWF will place in your Medical Record.

| | | |
|--|------------------------------|-----------------------------|
| Do you have a Living Will? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a Health Care Surrogate? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a Durable Power of Attorney? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Signature of Patient/Responsible Party/Guarantor: _____ **Date:** _____



Patient Dental History

| | | |
|---|--|--|
| Reason for today's visit: | | |
| Date of last medical visit: | | |
| Have you had any serious illnesses or operations including head, neck or jaw injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| If yes, please describe: | | |
| Do you have a history of fainting? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what was the cause: | | |
| Are you taking, or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| If so, please list all: | | |
| Has your medical doctor ever told you to take medication for a heart murmur prior to any Dental Treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| If yes, please list: | | |
| Do you have any allergies to medications or latex based products? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| If yes, please list: | | |
| Do you smoke or use any tobacco products? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| Have you ever had abnormal or prolonged bleeding after a dental extraction? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| Do you have any slow healing wounds? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| Are you pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO Due date: _____ Nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| Have you ever had a blood transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, what year? _____ | | |
| Are you HIV positive? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have AIDS? <input type="checkbox"/> YES <input type="checkbox"/> NO CD4+ Count: _____ | | |
| Have you ever been diagnosed with any of the following: Check all that apply | | |
| Autoimmune Disease <input type="checkbox"/> | Heart Attack/Stroke <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Muscular Disease <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Psychiatric/Behavioral Problems <input type="checkbox"/> | Liver Disease <input type="checkbox"/> |
| Developmental Delay <input type="checkbox"/> | Respiratory Disease <input type="checkbox"/> | Tumor/Growth <input type="checkbox"/> |
| Heart Disease <input type="checkbox"/> | Rheumatism Arthritis/Osteoarthritis <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> |
| Heart Murmur <input type="checkbox"/> | Skin Disease (Eczema, Rosacea) <input type="checkbox"/> | Jaundice or Hepatitis <input type="checkbox"/> |
| High Blood Pressure <input type="checkbox"/> | Stomach Intestinal Disease <input type="checkbox"/> | Other: _____ |
| Do you have a history of, or, currently being treated for any of the following: Check all that apply | | |
| Artificial Heart Valves <input type="checkbox"/> | Previous infective endocarditic diagnosis <input type="checkbox"/> | |
| Transplant <input type="checkbox"/> | Congenital Heart Disease <input type="checkbox"/> | |
| Joint replacement <input type="checkbox"/> | Pacemaker <input type="checkbox"/> | |
| If checked, please explain: _____ | | |
| Have you ever been or are currently being treated for cancer with chemotherapy or radiation? (circle one or both) | | |
| If yes to chemotherapy: When was your last cycle? _____ When is your next cycle? _____ | | |
| Do you currently have a port (Infusaport/Hickman Venous)? _____ | | |
| If yes to radiation: When was the last therapy given? _____ | | |
| If you are scheduled for therapy, when will you start? _____ | | |

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____