Sign-In Information Sheet

Date:	Arrival time:	☐ AM ☐ PM	
Reason for Visit:			
Last Name:	First Name:	Middle Name:	
Please list any previous name or maiden name:			
SSN:	Sex: ☐ Male ☐ Female	Date of Birth:	
Race:	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Are you under 18? ☐ Yes ☐ No	
Name of Parent or Guardian:			
Street Address:			
Mailing Address:			
City:	State:	Zip Code:	
Home Phone:	Cell Phone:		
Insurance/Medicaid:		Are you pregnant? ☐ Yes ☐ No	

Florida Department of Health in Wakulla County
NO SHOW POLICY

! out of 4 clients of the Florida Department of Health in Wakulla County does not show up for their medical or dental appointment. When an appointment is broken, no client is served in that timeslot. All clients deserve the best chance to improve their health, so we ask for your support.

As of March 18, 2010, a NO SHOW POLICY went into effect. You may book an appointment for yourself or a child, but *if you are not able to keep your appointment as scheduled you must notify us at least 24 hours in advance*. This will be considered a Cancelled Appointment. If the appointment is not cancelled and you do not show up for your appointment, this will be considered a NO SHOW and will be recorded as such. ***If you have 3 or more NO SHOWS in a 12-month period, you will not be allowed to book appointments for up to one year.*** Depending on the clinic, you may have the option to come in and wait to be seen if an appointment becomes available.

The day prior to your DENTAL appointment we will attempt to contact you by phone to remind you of your appointment. Monday appointment reminder calls will be made on the Friday before due to the weekend closure. The patient is responsible for notifying the health department of the current contact information for this purpose.

I have read and understand the NO SHOW POLICY and will make every effort to contact the Florida Department of Health in Wakulla County when I am unable to keep my appointment.

Signature _____ **Date** _____

Witness _____ **Date** _____

INITIATION OF SERVICES

PART 1 **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: **Wakulla County Health Department**

Agency Address: **48 Oak Street, Crawfordville, FL 32327**

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 names 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

Client Name: _____

ID#: _____

DOB: _____

Original to file Copy to client

ADULT AND ADOLESCENT HEALTH HISTORY

Name _____
ID# _____
Date of Birth _____

Initial Date:		**Updates: 1.**	**2.**	
O = Negative U = Unknown X = Positive		Pt.	Fam.	Check and Detail Positive Findings - Note by Reference Number
1.	Stroke/Hypertension			
2.	Heart Disease/Rheumatic Fever			
3.	Diabetes			
4.	Cancer			
5.	Congenital/Genetic Disorders			
6.	Blood Disorders/Sickle Cell			
7.	Lung/Tuberculosis/Asthma			
8.	Headache/Seizures			
9.	Neuro/Mental/Emotional Health			
10.	Breast Disease			
11.	Gallbladder/Liver			
12.	Kidney/UTI			
13.	G.I. Disease			
14.	Skin/Skeletal			
15.	Thyroid/Endocrine			
16.	Phlebitis/Varicosities			
17.	STD/HIV Infection			
18.	Pelvis Infections/Disorders			
19.	Mother took DES			
20.	Fertility Problems			
21.	Hospital/Surgery/Accidents			
22.	Blood Transfusion			
23.	Other			

Allergies: Drug Food: Other:

Medications: Current:

If pregnant, list other medicines taken this pregnancy:

*Circle NO or YES where applicable:

Tobacco: NO YES Type: Amount: Stopped (Date):

Alcohol: NO YES Type/Amount: Street Drugs: NO YES Type/Amount:

Tobacco/Alcohol/Drugs: Past Problems: NO YES Date of Last Use: Therapy:

Immunizations: (Date) MMR: Td: Flu: Pneu.: HBV:

Tuberculosis (Date): PPD Date: Result: mm. CXR Date: Result:

Prior Treatment: Case Preventive: Date: From: To:

Nutrition:

Recent Weight Change: NO YES (Describe)

Exercise: (20 min. 3x/wk) NO YES (Describe)

Seat Belt Use: Always Sometimes Never

School/Work Attendance/Exposures:

Sexual History: Age at first intercourse:

Sexually active since 1978? NO YES How many partners in the past 5 years? How many partners in the past year?

Sex w/ male? NO YES Victim of sexual assault? NO YES

Sex w/ female? NO YES Sex w/ injecting drug user? NO YES

Used injecting drugs? NO YES Sex w/ person w/ man who had sex w/ a man? NO YES

Sex while using non-inj drugs? NO YES Sex w/person who had HIV/AIDS? NO YES

Sex for drugs/money? NO YES Sex w/person w/other HIV/AIDS risk? NO YES

Contraceptive History: Method last used/now using:

Other methods used:

Problem(s) with methods:

Violence/Abuse in the family? NO YES

Signature/Title:

1. Signature/Title:

2. Signature/Titile: