Sign-In Information Sheet

Date _____ Arrival Time _____ Reason for Visit _____

Last Name _____ First _____ Middle _____

Please list any previous name or Maiden name: _____

SSN _____ Sex _____ DOB _____

Race _____ Marital Status (circle one) M D S W Are you under 18? Yes ☐ No☐

Parent or Guardian _____

Street Address _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Insurance/Medicaid _____ Are you pregnant? Yes☐ No☐

WAKULLA COUNTY HEALTH DEPARTMENT NO SHOW POLICY
Effective March 18, 2010

1 out of 4 clients of the Wakulla County Health Department (WCHD) 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.

On March 18, 2010 a No Show policy will go 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 WCHD at least 24 hours before the scheduled appointment. This will be considered a Canceled Appointment. If the appointment is not canceled and you do not show up for your appointment this missed appointment will be recorded as a No Show. 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 prior due to the weekend closure. The patient is responsible for notifying WCHD of their current contact information for this purpose.

Thank you for your cooperation.

I have read and understand the No Show Policy and will make every effort to contact the WCHD when I am unable to keep my appointment.

Signature: _____ Date: _____

Witness: _____ Date: _____

FLORIDA DEPARTMENT OF HEALTH

INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: _____

Agency Address: _____

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, 11/08 | Original to file Copy to client

FLORIDA DEPARTMENT OF HEALTH

ADULT AND ADOLESCENT HEALTH HISTORY

(Subjective Data Base)

Name: _____

ID #: _____

Date of Birth: _____

Initial Date _____ Updates: 1. _____ 2. _____

Purpose of Initial Visit: _____

O = Negative X = Positive U = Unknown	Pt.	Fam.	Check & 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/Rh			
7. Lung/Tuberculosis/Asthma			
8. Headaches/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. Pelvic 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. 3 X wk.) No Yes (Describe) _____

Seat Belt Use: Always _____ Sometimes _____ Never _____

School/Work Attendance/Exposures: _____

Sexual History: _____ Age at first intercourse: _____

Sexually active since 1978? Yes No How many partners in past 5 years? ____ How many partners in past year? ____

Sex w/male	Yes	No	Victim of sexual assault	Yes	No
Sex w/female	Yes	No	Sex w/injecting drug user	Yes	No
Used injecting drugs	Yes	No	Sex w/man who had sex w/a man	Yes	No
Sex while using non-inj drugs	Yes	No	Sex w/person w/HIV/AIDS	Yes	No
Sex for drugs/money	Yes	No	Sex w/person w/other HIV/AIDS risk	Yes	No

Contraceptive History

Method last used/now using: _____

Other methods used: _____

Problem(s) with methods: _____

Violence/abuse in the family? Yes No

Signature/Title: _____

1. Signature/Title: _____

2. Signature/Title: _____

DH 3113, 10/96
(Replaces HRS-H Form 3113 which may be used)
(Stock Number: 5744-000-3113-1)