FLORIDA DEPARTMENT OF HEALTH

VOLUNTEER HEALTH CARE PROVIDER PROGRAM - FINANCIAL ELIGIBILITY FORM

To better serve you, please check one that applies best. I would like:

☐ A Filling ☐ A Tooth Removed
☐ A Cleaning ☐ Denture Repair

BOX 1 Do you have insurance that covers your health or dental condition? YES _____NO _____
Does anyone in your family have an active FL Medicaid card? YES ____ NO ____

Name of the card holder and Medicaid No. _____

Patient's/Head of Household's Name: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: _____
(STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: _____ Name of Contact: _____

BOX 2
Family Size: Adults____ Under 18 ____ 18-21--Student ____ Unborn _____ Family Size TOTAL _____

FAMILY MEMBERS	DOB	EMPLOYER	GROSS MONTHLY EARNED INCOME	GROSS MONTHLY UNEARNED INCOME (Do not include TANF or SSI)
SELF			$	$
SPOUSE			$	$
CHILD			$	$
CHILD			$	$
		INCOME TOTALS	$	$
			TOTAL FAMILY INCOME Earned + Unearned =	TOTAL FAMILY INCOME $_____

BOX 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)

Step 1. **"TOTAL FAMILY INCOME"** for family unit (Earned and unearned income). (1) $_____(Above)

Step 2. Subtract $90 for EACH employed member of the family unit. (2) $_____(Minus)

(2a) $_____ (Total)

Step 3. Subtract childcare PAID each month (up to $175 per child age 2 and older; up to $200 per child under age 2). (3) $_____(Minus

(3a) $_____(Total)

Step 4. Subtract up to $50 per month of total child support received. (4) $_____ (Minus)

Step 5. **ADJUSTED TOTAL NET INCOME FOR FAMILY UNIT.** (5) $_____(Total)

BOX 4 USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit.

_____ _____
SIGNATURE OF PATIENT/PARENT OR GUARDIAN **DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE DATE**

(VALID FOR ONE YEAR) Expiration date: _____

MEDICAL HISTORY

Chart # _____

Patient Name _____ D.O.B. _____

Address _____ City _____ State ____ ZIP _____

SSN _____ Phone _____ Email _____

Legal Guardian/Caregiver _____ Phone _____

Emergency Contact: Name _____ Phone _____

How did you hear about us? _____

When was your last dental exam _____ Dentist's Name _____

Why have you come to see us today? _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
Physician's Name: _____
Clinic Name : _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been involved in a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Have you received or are you currently receiving any of the following drugs: Fosamax, Actonel, Boniva, Aredia or Zometa? ☐ Yes ☐ No If yes, please explain: _____

Do you reqiure a PreMed? ☐ Yes ☐ No If yes, please explain: _____

Women: Are you… ☐ Pregnant / Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐	Acrylic	☐	Aspirin	☐	Codeine	☐	Latex
☐	Local Anesthetics	☐	Metal	☐	Penicillin	☐	Sulfa Drugs
☐	Tetracycline	☐	Other: _____				

Comments: _____

_____

_____

_____

Do you have, or have you had, any of the following?

☐	**AIDS / HIV Positive**	☐	**Epilepsy or Seizures**	☐	**Pacemaker**
☐	**Alzheimer's Disease**	☐	**Excessive Bleeding**	☐	**Pregnancy**
☐	**Anemia - Chronic**	☐	**Glaucoma**	☐	**Pre-Medication**
☐	**Angina Pectoris**	☐	**Heart Attack / Congestive Heart Failure**	☐	**Psychiatric Care**
☐	**Antipsychotic Medications**	☐	**Heart Murmur *Only if Pre-Med is required**	☐	**Radiation / Chemotherapy**
☐	**Arthritis**	☐	**Heart Valve Replacement**	☐	**Respiratory Problems**
☐	**Artificial Heart Valve**	☐	**Hepatitis**	☐	**Rheumatic Fever**
☐	**Artificial Joint**	☐	**Herpes**	☐	**Rheumatism**
☐	**Asthma**	☐	**High Blood Pressure**	☐	**Shingles**
☐	**Autism**	☐	**Kidney Disease**	☐	**Spina bifida**
☐	**Cancer**	☐	**Leukemia**	☐	**Stomach Problems**
☐	**Chemical Dependency Alcohol / Drugs**	☐	**Liver Disease**	☐	**Stroke**
☐	**Congenital Heart Disorder / Defect**	☐	**Meniere's Disease (Dizziness)**	☐	**Thyroid Disease**
☐	**Coagulation Disorder**	☐	**Mental Disorder**	☐	**Tuberculosis**
☐	**Coumadin Therapy**	☐	**Mitral Valve Prolapse**	☐	**Tumors**
☐	**Crohn's Disease**	☐	**Nervous Disorder**	☐	**Ulcers**
☐	**Depression**	☐	**Organ Transplant**	☐	**Venereal Disease / STD's**
☐	**Diabetes**				

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____