SULZBACHER VILLAGE
PEDIATRIC HEALTH CENTER

Please read this entire page before beginning the application process

Your application will only be reviewed when all necessary items are returned and all the signatures are verified. In order to qualify for the sliding fee discount, you must complete this eligibility process. To make your registration as smooth as possible please complete the following:

- **Application** (this entire packet)
  - If your application is not complete you may be asked to return additional information. Please make sure there are signatures and dates where needed throughout the application.
- **Income verification: Total Gross Household Income:** Income before taxes or deductions – calculated for all household members age 19 and older based on income verifications from **any** or **all** of the following:

☐ Paychecks or pay stubs (4)
☐ Letter / telephone contact from your employer
☐ Letter from unemployment
☐ Notarized letter of support
☐ "The Work Number" website
☐ Taxi log or Manifest
☐ Other (rent money received, etc.)
☐ Letter from employer of pension / retirement award
☐ Verification from public / private agency (e.g., TANF/ADC, food stamps, shelter, social security, SSI, etc)
☐ Court order (e.g., settlement, alimony, child support, other)
☐ Confirmation letter from an approved agency
☐ Bank statement

- **Housing: Verification of Residency in Service Area (provide at least one of the following):**

☐ Driver's License
☐ Car registration
☐ Copy of lease or rental agreement or eviction notice
☐ Copy of mortgage coupon
☐ Letter from shelter (on shelter letterhead), Quest or HOPE Team
☐ Utility bill or other official document addressed to the patient at his/her address
☐ School record
☐ Notarized letter from roommate or landlord (Note: Roommate or landlord residence must be verified)

- Please bring an updated copy of your prescription medication list, including over-the-counter medications and vitamins.
- If you have any questions regarding this application before you come turn in your documents, please call (904) 394-4963 and leave a message with your name and phone number or email us at SulzbacherDental@SulzbacherJax.org
- Proof of income and housing is a HRSA requirement and must be provided to be a patient at our clinic.

Please wear a mask or face cover, bring a pen, all of your supporting documents, and photo ID.

Clinic location:

Sulzbacher Village: 5455 Springfield Blvd., Jacksonville, FL 32208 (904) 394-4963

Dental clinic hours: Tuesday, Wednesday and Thursday 8 a.m.-4 p.m., closed noon-1 p.m. for lunch

SULZBACHER VILLAGE
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Patient Registration

Patient's Legal Name: (first, middle, last): _____

Parent/Legal Guardian Name (first, middle, last): _____

Address: _____

City: _____State: _____ Zip: _____

Date of Birth: _____Social Security number: _____

Home phone: _____Cell or other phone: _____

Email Address: _____Preferred Pharmacy: _____

Number of individuals living in household: _____Average household income: _____
Name of emergency contact: _____
Relationship: _____Contact number: _____

How did you hear about our clinic:

Race	**Gender Identity**	**Sexual Orientation**	**Residence Status**
☐ Asian	☐ Male	☐ Straight	☐ US Citizen
☐ Native American	☐ Female	☐ Gay	☐ Legal Resident
☐ Other Pacific Islander	☐ Transgender Male	☐ Lesbian	☐ Immigrant Refugee
☐ Black/African American	☐ Transgender Female	☐ Bisexual	
☐ American Indian/Alaska Native	☐ Other	☐ Don't Know	**Ethnicity**
☐ White	☐ Choose not to disclose	☐ Choose not to disclose	☐ Hispanic
☐ More than one race			☐ Non-Hispanic

Does the patient have dental insurance? ☐ **Yes** (please circle one) ☐ **No**
Medicaid # _____ Liberty MCNA DentaQuest Other: _____

Is the patient currently homeless? **Yes** **No**
Has the patient been homeless in the last 12 months? ☐ **Yes** (please circle all that apply) ☐ **No**
Lived in transitional housing or treatment center Lived in a homeless shelter
Temporarily living with another family member/friend Lived on the street, in a car, park, etc.

By signing this document, I confirm that this information correctly describes the patient's insurance and living situation. I understand that giving false information may affect my ability to receive services. I understand that the Sulzbacher Clinic may check this information and I give them permission to do so.

I allow the Sulzbacher Village Pediatric Health Center to give treatment, perform exams/tests to find out what is wrong, take blood or other samples for lab tests (including HIV), teach the patient about health-related topics, allow medical /nursing/dental students and residents/interns to help with care, allow providers to prescribe medicines and to obtain medication history information.

Printed Patient Name (or legal representative): _____

Patient signature (or legal representative): _____Date: _____

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SULZBACHER VILLAGE
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ASSIGNMENT OF BENEFITS FORM

Name of Insured (print): _____

Social Security number: _____

I request that payment of authorized benefits, including Medicaid, if I am a Medicaid beneficiary, be made on my behalf to Sulzbacher, for any dental services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration (HCFA), my insurance carrier or other dental entity. A copy of this authorization will be sent to the HCFA, my insurance company or other entity, if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products and services received.

_____ _____
Patient Name (Printed) Relationship to Insured

_____ _____
Signature of Insured/Parent/Guardian Date

Patient Communication Preferences

Consent to call: Do you agree to be contacted by Sulzbacher via phone? These calls will primarily consist of appointment reminders, as well as communication from clinic staff about your care.

_____YES, I agree to receive phone calls from the clinic.
_____NO, I do NOT agree to receive calls from the clinic.

- If Yes, are we able to leave a voicemail if we are unable to reach you?
  _____YES, you may leave a voicemail on the phone number I have provided.
  _____NO, you may not leave a voicemail on the phone number I have provided.

Consent to text: Would you like to receive automated texts from the clinic? These texts will primarily consist of appointment reminders.

_____YES, I would like to receive automated texts from the clinic.
_____NO, I would not like to receive automated texts from the clinic.

- If yes, please provide the best mobile phone number to contact you: _____

By signing this document, I confirm that I agree to the above methods of communication from the clinic.

_____ _____
Signature of Patient Date

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SULZBACHER VILLAGE
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Disclosure of Protected Health Information and Privacy Authorization

Patient Name (first, middle, last): _____
Address: _____
City: _____State: _____Zip: _____
Social Security number: _____Date of Birth: _____

1. **Disclosure of health information for treatment, payment, and health care operations**
   I consent to the use and disclosure of the patient's protected health information for treatment, billing, and health care operations. I have read a copy of the Notice of Privacy Practices and understand that I have the following rights and privileges:
   - The right to review the Notice prior to signing the consent
   - The right to inspect and receive a copy of the patient's clinical information
   - The right to request to amend clinical information I feel is incorrect or incomplete
   - The right to request that Sulzbacher restricts the use and disclosure of the patient's personal health information
   - The right to revoke my permission at any time by giving written notice to Sulzbacher

This authorization will remain in effect until my death or the day I withdraw my permission in writing.
I would like to receive a copy of the Notice of Privacy Practices ☐ **Yes** ☐ **No**

I, _____, have read this consent form and the Notice of Privacy Practices. I understand that I am giving you consent to use and disclose the patient's health information for treatment, billing, and healthcare operations.

Signature of Patient/Legal Representative: _____Date: _____

2. **HIPAA Privacy Authorization: Who can see the patient's health information?** Please list any family member or others who may be involved in coordinating the patient's care.

Name	**Relationship to Patient**

How long can they see the patient's information?
☐ From _____to _____
☐ All past, present and future periods
What information can they see?
☐ Everything ☐ Everything EXCEPT the following (check all that apply)
☐ Mental Health Records ☐ HIV/AIDS/Other Communicable Disease Records
☐ Alcohol/Drug Abuse Treatment Records ☐ Other, Specify: _____

This medical information may be used by the person I authorize for medical treatment, billing or claims, discussions about the patient's health, or other purposes that I allow.

I understand that I have the right to revoke this authorization (in writing) at any time. I understand that any revocation is not effective on any information that has already been shared. I understand that I can refuse to sign this release and that my treatment, payment, enrollment, or eligibility for services will not be withheld.
Signature of Patient/Legal Representative: _____Date: _____

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Consent to Treat Minor without Parent/Guardian Present

Patient's Full Name: _____Date of Birth: _____

To allow for treatment of patients who are considered minors, it is necessary for a parent or legal guardian to give consent for treatment. In the event that a minor patient presents for a non-urgent appointment without a parent or legal guardian or a signed consent, treatment may be denied.

I give permission for the following individuals to bring the patient to their appointment:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I verify that these individuals are at least 18 years of age. I also give this individual permission to make decisions regarding the patient's dental treatment, medical treatment (if necessary should an emergency arise) and behavior management.

I, _____(print parent/guardian name) consent to:

_____ Emergency or urgent care when I cannot be reached.

_____ Routine dental care, which may include, but not limited to: dental examinations, Prophylaxis (cleaning), fluoride treatment, X-rays and any and all other treatment previously discussed and agreed upon by the parent/legal guardian.

I can be reached at the following number if there are any questions: _____

I/We _____authorize Sulzbacher to provide treatment.
Printed Parent/Guardian name

_____ _____
Signature of Parent/Legal Guardian Date

_____
Relationship to Patient

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Dental Treatment Consent Form

- **Drugs and Medications:** I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and /or anaphylactic shock (severe allergic reaction causing hospitalization and possible death).
- **Changes in Treatment Plan:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination.
- **Removal of Teeth:** If the teeth are savable/restorable, the alternatives to removal of teeth are root canal therapy, periodontal surgery, etc. I understand that removing teeth does not always remove all the pain as I may have pain from other teeth, muscles or other source. I understand the risks involved in having a tooth removed, some of which are pain (including TMJ), swelling, spread of infection, remaining tooth root, damage of adjacent teeth, dry sockets, loss of feeling in my teeth, lips, tongue and surrounding tissue (can be permanent), fractured jaw or sinus exposure. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
- **Crowns/Bridges:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns which may come off while I am waiting for my permanent crown to be fabricated.
- **Dentures** (complete or partial): I realize that full or partial dentures are artificial and constructed of plastic, metal and/or porcelain. I understand that these replacements of my natural teeth will not function as natural teeth do. I can expect to experience sore spots, looseness, loss of taste sensation, difficulty speaking, difficulty chewing and other complications inherent to removable appliances. I understand that most dentures require relining within 3 to 12 months of placement and this fee is NOT included in the original cost.
- **Endodontic Treatment** (root canal): I realize that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment up to and including possible tooth removal.
- **Periodontal treatment:** I understand that serious gum problems can lead to bone infection or bone loss that can lead to the loss of my teeth. Some treatments include scaling and root planing, periodontal surgery and tooth extraction. I understand that I must follow through with homecare in order to achieve periodontal health and other treatments such as fillings, crowns and partials may be delayed while the periodontal condition is compromised.
- I consent to receive treatment under public health emergencies and understand that treatment options may be modified accordingly.
- I understand that the initial exam/care will be provided by a General Dentist unless treatment needs fall outside of this scope, in which case Sulzbacher will facilitate internal and/or external referral to a Pediatric Dentist.
- I understand and agree that guardians/parents will not be permitted to stay in the treatment area while treatment is being rendered with the possible exception of examination and consultation visits.
- **I understand that I am being provided this treatment at a low cost to me and the only way that the Sulzbacher can provide this care at this cost is through the use of multiple dentists and often volunteers. I further understand that it is unlikely that I will be able to choose my providing dentist. Lastly, I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.**

Patient Name (printed):_____

Parent/Legal Guardian Signature:_____ Date _____

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CONSENT FOR SILVER DIAMINE FLUORIDE

Facts for consideration:

- Silver Diamine Fluoride (SDF) is an antimicrobial liquid. We use SDF on cavities to help stop tooth decay. We also use it to treat tooth sensitivity.
- The procedure: 1) Dry the affected area 2) Place a small amount of SDF on the affected area 3) Allow SDF to dry for one minute 4) Place fluoride varnish.
- Treatment with SDF does not eliminate the need for dental fillings or crowns to repair function or esthetics.
- I should not be treated with SDF if 1) I am allergic to silver 2) there are painful sores or raw areas on my gums (i.e., ulcerative gingivitis) or anywhere in my mouth (i.e., stomatitis).

Benefits of receiving SDF:

- SDF can help stop tooth decay.
- SDF can help relieve sensitivity.

Risks related to SDF included, but are not limited to:

- The affected area will stain black permanently. Healthy tooth structure will not stain. Stained tooth structure can be replaced with a filling or a crown.
- Tooth-colored fillings and crowns may also discolor if SDF is applied to them. Normally this color change is temporary and can be polished off.
- If accidentally applied to the skin or gums, a brown stain may appear that causes no harm, cannot be washed off, and will disappear in 1-3 weeks.
- You may notice a metallic taste. This will go away rapidly.
- If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such as repeat SDF, a filling or crown, root canal treatment, or extraction.
- These side effects may not include all the possible reactions and/or interactions reported by the manufacturer.
- If you notice other effects, please contact your dental provider.
- Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay and no guarantee of success is granted or implied.

Alternatives to SDF, not limited to the following:

- No treatment, which may lead to continued deterioration of tooth structures. Symptoms may increase in severity and tooth loss may occur.
- Depending on the location and extent of the tooth decay, other treatment may include placement of fluoride varnish, a filling or crown, extraction, or referral for advanced treatment.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND ALL MY QUESTIONS WERE ANSWERED.

_____

Patient name

_____ _____

Patient/guardian signature Date

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Name: _____DOB: _____ Today's Date: _____

HEALTH

Primary Care Physician's Name: _____ Phone:_____

Date of Last Physical Exam:_____ Is the patient taking any medications right now? ( ) Yes ( ) No

Please list any medications/vitamins/supplements the patient is currently taking (continue on back if needed).

List Medications:	Treatment for:	Date Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does this patient require premedication before dental treatment? ( ) Yes ( ) No If yes, please explain_____
Does this patient have any allergies? ( ) Yes ( ) No If yes, please explain_____
Has this patient ever had a drug reaction? ( ) Yes ( ) No If yes, please explain _____
Has this patient ever been hospitalized? ( ) Yes ( ) No If yes, please explain_____
Is this patient currently under the care of a physician due to a specific condition? ( ) Yes ( ) No

If yes, condition_____ Specialist's Name:_____

Specialty: _____Phone: _____Last Exam Date:_____

Does the patient currently smoke? **Yes** **No** Has the patient ever smoked? **Yes** **No**

Does this patient have or have they ever had any of the following conditions?

- ☐ ADHD/Hyperactivity
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Autism
- ☐ Birth Defects
- ☐ Bleeding Problems
- ☐ Blood Disease
- ☐ Blood Transfusions
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chronic Cough >3 weeks
- ☐ Cleft Lip/Palate
- ☐ Delayed Speech Developmen
- ☐ Depression
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Dizziness
- ☐ Down Syndrome
- ☐ Fainting Spells
- ☐ Growth Problems
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Hearing Loss/Impairment
- ☐ Heart Condition/Murmur
- ☐ Hepatitis/Liver Disease
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Latex Sensitivity
- ☐ Migraines
- ☐ Pregnancy
- ☐ Premature/Low Birth Weight
- ☐ Psychiatric/Emotional Disorder
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Seizures/Epilepsy
- ☐ Sickle Cell
- ☐ Sinus Problems
- ☐ Sleep Disorder
- ☐ Special Healthcare Needs
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Vision Problems
- ☐ Other:_____

SULZBACHER VILLAGE
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Name: _____DOB: _____ Today's Date: _____

DENTAL

Why is this patient here today? What is your main dental concern?_____

Previous dentist's name:_____

Phone:_____ Date of last exam:_____

Does this patient have and/or do any of the following?

- ☐ Toothache? Where?_____
- ☐ Accident/Injury to teeth-When?_____ _____ How?_____
- ☐ Discolored/Stained teeth
- ☐ Bleeding Gums
- ☐ Cold/Canker sores
- ☐ Tooth grinding/clinching
- ☐ Snoring/Mouth Breathing
- ☐ Crowded/Spaced Teeth
- ☐ Pacifier/Thumb Habit
- ☐ Sleeping with bottle/breast fed
- ☐ Orthodontic Treatment
- ☐ Brush teeth ( )alone ( )supervised ( )assisted
- ☐ Fluoride toothpaste
- ☐ Dental floss
- ☐ Eat sweets or drink juices daily
- ☐ Fluoride supplement

BEHAVIOR

How do you think this patient has reacted to past medical or dental procedures? ( ) Well ( ) Poor

How do you expect this patient to react in the dental chair? ( ) Well ( ) Poor

What are the patient's interests and hobbies?

_____

Are you permitted by law (by right as a natural parent, legal adoption, or court order) to provide consent for dental treatment of this patient? ( ) Yes ( ) No

Signature: _____ Printed Name:_____

Relationship to patient:_____ Date:_____