PATIENT INTAKE FORM

Instructions:

1. **Print this form. Note after hours information listed below.**
2. **Complete the form, then call the appropriate clinic below, to make your appointment.**
3. **Bring your completed form with you or fax it to your selected clinic ahead of time.**

Bay County

PanCare Health – Dental Clinic
403 E. 11th Street
Panama City, FL 32401
Phone: (850) 767-3350
Fax: (850) 767-3353

PanCare Health – Medical Clinic
2309 East 15th Street
Panama City, FL 32401
Phone: (850) 747-5272
Fax: (850) 747-5274

PanCare Health – Dental and Medical Clinic
12427 Highway 231
Youngstown, FL 32466
Phone: (850) 753-3246
Fax: (850) 753-3342

Calhoun County

PanCare Health – Medical Clinic
16875 North Cayson Street
Blountstown, FL 32424
Phone: (850) 674-2244
Fax: (850) 674-2249

Franklin County

PanCare Health – Dental Clinic
106 NE 5th Street
Carrabelle, FL 32322
Phone: (850) 697-5000
Fax: (850) 697-1104

Gulf County

PanCare Health – Dental and Medical Clinic
2475 Garrison Avenue
Port St. Joe, FL 32456
Phone: (850) 229-1043
Fax: (850) 229-1104

PanCare Health – Dental Clinic
807 West Highway 22
Wewahitchka, FL 32465
Phone: (850) 639-2028
Fax: (850) 639-2007

Holmes County

PanCare Health – Medical Clinic
495 St. Johns Road
Bonifay, FL 32425
Phone: (850) 547-5547
Fax: (850) 547-5553

Jackson County

PanCare Health – Dental and Medical Clinic
4126 Independent Drive
Marianna, FL 32448
Phone: (850) 394-4907
Fax: (850) 394-4981

Liberty County

PanCare Health – Medical Clinic
11033 NW State Road 20
Bristol, FL 32321
Phone: (850) 643 -1155
Fax: (850) 643-1163

Walton County

PanCare Health – Dental and Medical Clinic
479 East Highway 20
Freeport, FL 32439
Phone: (850) 880-6568
Fax: (850) 880-6583

PanCare Health – Medical Clinic
278 Church Road
Bruce, FL 32455
Phone: (850) 835-1015
Fax: (850) 880-6583

Washington County

PanCare Health – Medical Clinic
1414 Main Street, Suite 4
Chipley, FL 32428
Phone: (850) 676-4926
Fax: (850) 676-4929

After Hours

For non-emergency medical assistance please call the appropriate clinic listed above.
For emergency medical assistance please call 911.

PANCARE OF FLORIDA, INC.

PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Social Security Number | **Date of Birth** | **U.S. Military Service (☑ one):** ☐ None ☐ Currently Serving ☐ Discharged

Address | **City** | **State** | **Zip Code** | **County**

Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )	**Email**

Marital Status (☑ one): ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Primary Language Spoken: ☐ Limited English

Patient's Relationship to Responsible Party (☑ one): ☐ Self ☐ Spouse ☐ Natural Child ☐ Parent ☐ Foster Child ☐ Foster Parent

Gender (☑ one): ☐ Female ☐ Male ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐ Choose Not To Disclose

Sexual Orientation (☑ one): ☐ Choose Not To Disclose ☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something Else ☐ Don't Know

Race (☑ one): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ More Than One Race ☐ Choose Not To Disclose

Ethnicity (☑ one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Choose Not To Disclose

Are you a migrant/seasonal worker or a family member of a migrant/seasonal worker? ☐ Yes ☐ No

What is your annual income? ☐ $0-$12,490 ☐ $12,491-$15,614 ☐ $15,615-$18,735 ☐ $18,736-$21,858 ☐ $21,859-$24,980 ☐ $24,981 & UP

Number of people in household:_____

Emergency Contact	**Phone** ( )	**Relationship to Patient**

RESPONSIBLE PARTY INFORMATION (enter name of person *FINANCIALLY* responsible for your account)

Last Name | **First Name** | **Middle Initial**

Mailing Address | **City** | **State** | **Zip Code** | **County**

Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )	**Date of Birth**	**Social Security Number**

INSURANCE COMPANY – *INCLUDING MEDICAID*

Primary Insurance | **ID#** | **Group #** | **Insurance Company Address**

Name of Insured | **Date of Birth** | **Insured's Employer**

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Natural Child ☐ Step Child Parent ☐ Foster Child ☐ Foster Parent

Secondary Insurance | **ID#** | **Group #** | **Insurance Company Address**

Name of Insured | **Date of Birth** | **Insured's Employer**

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Natural Child ☐ Step Child Parent ☐ Foster Child ☐ Foster Parent

Assignment and Release: *I authorize my insurance benefits to be paid directly to PanCare Health. I also authorize PanCare Health to release any information required to process this claim.*

SIGNATURE:_____ **DATE:**_____

Patient Name:_____ Birth Date:_____
Last First MI

HEALTH HISTORY

Reason for Today's Visit:_____

Check ☑ all that apply to you

	ADHD		Coughing Up Blood		Heart Attack		Radiation
	Alcohol Use		Dark or Black Stools		Heart Catheterization		Rectal Bleeding
	Anemia		Depression		Heart Disease		Rheumatoid Arthritis
	Anxiety		Diabetes		Heart Murmur/Irregular Beat		Seizures
	Artificial Joints		Diarrhea		Hepatitis A, B, or C		Sexual Difficulties
	Asthma		Dizziness		High Blood Pressure		Shortness of Breath
	Autism		Drug Addictions		HIV/AIDS (Risk or Exposure)		Sickle Cell Anemia
	Blood in Stools/Urine		Earache		Jaundice		Sleep Difficulties
	Blood Disease		Emphysema		Kidney Disease/Stones		Smoker
	Blood Transfusion		Epilepsy		Liver Disease		Street Drug Use
	Bowel Changes		Excessive Bleeding		Marital Problems		STDs
	Cancer		Fainting		Mental Health Disorder		Stroke
	Changing Moles		Fractures		Osteoarthritis		Suicide Attempt
	Chest Pain		Gallbladder Disease		Pacemaker		Thyroid Disease/Problems
	Cholesterol (high)		Gout		Pneumonia		Tobacco Use
	Chronic Cough		Hay Fever		Pregnant – Due Date:		Tuberculosis (TB)
	Constipation		Head Injury		Prostate Problems		Wheezing

Last Pap Smear:_____
Last Mammogram:_____
Number of Pregnancies:_____

Number of Births:_____
Birth Control Method: ☐None ☐Pill ☐Condoms ☐IUD
☐Shots ☐Tubal ☐Vasectomy ☐Other _____

Allergies:_____

Medications:_____

_____

Pharmacy Name and Location:_____

Hospitalization/Surgeries:_____

Dental Pain □ Yes □ No, If yes, explain:_____

FAMILY HISTORY

Check ☑ all that apply to you and your family

	Alcohol Abuse		Cancer		Diabetes		Heart Disease
	Asthma		Depression		Glaucoma		High Blood Pressure

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Patient, Parent, or Guardian Signature Date

_____ _____
Dental Provider Signature Date

_____ _____
Medical Provider Signature Date

Patient Name:_____ Birth Date:_____
Last First MI

Initials_____ Broken Appointment and Confirmation Policy Agreement

We enforce the two (2) broken appointment policy meaning that after 2 broken appointments within a twelve (12) month period, we will no longer schedule that patient, any adult or child living in the same residence, or any adult responsible for a child's medical/dental/behavioral health treatment for one year from the date of the second broken appointment.

It is the responsibility of the patient (or parent/guardian, in case of a child) to notify the clinic any time they will not be available for their appointment, at least 24 hours prior to the scheduled appointment.

As a patient of the medical/dental/behavioral health clinic it is your responsibility (or parent/guardian, in case of a child) to confirm your appointment. We make every effort to call and confirm your scheduled appointment the morning prior to the appointment. However, without confirmation from you, we will remove your appointment from the schedule and consider it a broken appointment.

Please make sure that your phone number is correct on your file and if your phone number changes you must contact the medical/dental/behavioral clinic to advise us of the change or again, we may cancel your appointment resulting in a broken appointment if we are unable to reach you.

Initials_____ Release of Medical/Dental/Behavioral Health Information

It is the provider's responsibility to ensure that the provider-patient relationship is confidential. Under the requirements of the Health Insurance Portability and Accountability Act (HIPAA) we are not allowed to release any patient information without the patient's consent. If you wish to have your medical/dental/behavioral health or billing information released to a family member, friend, or legal representative, you must sign this form. Signing this form will only give consent to release this information to the persons indicated below. This consent form will not allow PanCare Health to release any other information to these persons. You have the right to revoke this consent in writing.

I authorize/allow PanCare Health to release my medical/dental/behavioral health and/or billing information to the following individual(s):

NAME	RELATIONSHIP TO PATIENT

Initials_____ Notice of Privacy Practices/Patient Rights and Responsibilities

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this organization's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I also understand that the Patient Rights and Responsibilities are available for my review and that I have responsibilities regarding my care.

I understand that:

- I have the right to review this organization's Notice of Privacy Practices prior to signing this acknowledgement;
- I have the right to review the Patient Rights and Responsibilities prior to signing this acknowledgement;
- This organization reserves the right to change these documents and that these documents are available to me upon request at my next visit, and on the organizations web site: www.pancarefl.org.

Patient Name:_____ Birth Date:_____
Last First MI

Initials_____ Consent for Treatment

I hereby authorize PanCare Health, its facilities and treatment centers, its affiliated providers, dentists, dental hygienists, ARNPs, physician assistants, psychologists, social workers and other medical personnel to administer examinations and treatments as deemed medically necessary.

Initials_____ Non-Covered Insurance Services

I understand that I am financially responsible for any charges not paid by the insurance and that the insurance is filed as a courtesy. I understand that the insurance co-pays are estimated and are not a guarantee of benefits. I also confirm that I will pay for any charges that will be incurred due to having a non-covered service performed.

Initials_____ Advance Directives

I understand that I have the right to have an advance directive.
□ I currently have an advance directive:
□ Living Will □ Health Care Surrogate □ Durable Power of Attorney for Health Care
□ I do not have or want an advance directive
□ I would like more information regarding advance directives

We encourage all patients to complete an advance directive, which allows you to state your preferences for medical treatments and to select an agent or person to make your health care decisions in case you are unable to do so or if you want someone else to make decisions for you. Further information on advance directives is available on our web site www.pancarefl.org.

If you already have an advance directive, please bring a copy with you at your next visit. Your advance directive will be placed in your medical record.

Acknowledgement

I have initialed the Broken Appointment and Confirmation Policy Agreement, Release of Medical/Dental/Behavioral Health Information, Notice of Privacy Practices/Patient Rights and Responsibilities, Consent for Treatment, Non-Covered Insurance Services, and Advance Directives. By doing so I acknowledge that I have read all of the aforementioned statements and will abide by the same and if I do not this may disqualify me from receiving care from PanCare Health Medical/Dental Clinics.

_____ _____
Signature of Patient/Legal Representative Date

_____
Printed Name of Patient/Legal Representative

Patient Name:_____ Birth Date:_____
Last First MI

Sliding Fee Application

I, _____, am requesting to be considered for the sliding fee scale discount offered by PanCare Health. By filling out this form and returning it for processing, I am asserting that the facts contained within are true and correct to the best of my knowledge. I understand that if the information proves fraudulent, PanCare reserves the right to cancel my Sliding Fee Scale status and bill me in full for all previous visits.

Current Income: Please provide ALL requested income verification for ALL household members with your paperwork. Your appointment will need to be rescheduled if you do not provide this with your packet.

Employer: _____

Employer's Phone Number: _____

Monthly Income: _____

Spouse/Significant Other's Employer: _____

Monthly Income: _____

Any other income, including any other working adults that live in the home: _____

List all people (including children) in your household:

Last Name, First Name	Date of Birth	Relationship

Attach

- A copy of your **CURRENT** tax return
- A copy of a pay stub for the last month for all working adults in the household
- SSI/Disability proof of benefits
- Child Support

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
PanCare Representative's Verification/Signature Date