



## **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.

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#### **Bay County**

PanCare Health – Dental Clinic  
403 E. 11th Street

Panama City, FL 32401

Phone: (850) 767-3350

Fax: (850) 767-3353

PanCare Health – Gulf Coast

5230 Highway 98, Rosenwald Bldg.

Panama City, FL 32401

Phone: (850) 873-3535

Fax: (850) 772-6686

PanCare Health – Medical Clinic

2235 East 15th Street Building B

Panama City, FL 32405

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

401 Cecil G. Costin Sr. Blvd.

Port St. Joe, FL 32456

Phone: (850) 229-1043

Fax: (850) 229-1104

#### **Gulf County (continued)**

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

PanCare Health – Dental and Medical Clinic

5336 East 10<sup>th</sup> Street

Malone, FL 32445

Phone: (850) 569-2053

Fax: (850) 569-2062

#### **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

#### **Washington County**

PanCare Health – Medical Clinic

1440 Main Street

Chipley, FL 32428

Phone: (850) 676-4926

Fax: (850) 676-4929



## PATIENT INTAKE FORM

PATIENT INFORMATION				
Last Name		First Name		Middle Initial
Date of Birth			U.S. Military Service ( <input checked="" type="checkbox"/> one): <input type="checkbox"/> None <input type="checkbox"/> Currently Serving <input type="checkbox"/> Discharged	
Address		City	State	Zip Code
Home Phone (    )	Work Phone (    )	Cell Phone (    )	Email	
Marital Status ( <input checked="" type="checkbox"/> one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		Primary Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish Other: _____		Patient's Relationship to Responsible Party ( <input checked="" type="checkbox"/> one): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent
Race ( <input checked="" type="checkbox"/> one): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> More Than One Race <input type="checkbox"/> Choose Not To Disclose				
Ethnicity ( <input checked="" type="checkbox"/> one): <input type="checkbox"/> Chicano/Chicana <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic <input type="checkbox"/> Latino/Latina <input type="checkbox"/> Spanish <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Non-Hispanic/Latino/Latina/Spanish <input type="checkbox"/> More Than One Ethnicity <input type="checkbox"/> Choose Not To Disclose				
Are you a migrant/seasonal worker or a family member of a migrant/seasonal worker? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female				
What is your annual income? <input type="checkbox"/> \$0-\$15,960 <input type="checkbox"/> \$15,961-\$19,950 <input type="checkbox"/> \$19,951-\$23,940 <input type="checkbox"/> \$23,940-\$27,930 <input type="checkbox"/> \$27,930-31,920 <input type="checkbox"/> \$31,920 & 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
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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Stepchild Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent				
Secondary Insurance		ID#	Group #	Insurance Company Address
Name of Insured		Date of Birth		Insured's Employer
Relationship to Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Stepchild Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent				

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Last First MI

**HEALTH HISTORY**

Reason for Today's Visit: \_\_\_\_\_

Have you had or do you currently have any of the following? Check  all that apply.

<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Coughing Up Blood	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/>	COVID-19	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Radiation Treatments
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Dark or Black Stools	<input type="checkbox"/>	Heart Catheterization	<input type="checkbox"/>	Rectal Bleeding
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart Murmur/Irregular Beat	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Hepatitis A, B, or C	<input type="checkbox"/>	Sexual Difficulties
<input type="checkbox"/>	Autism	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Blood in Stools/Urine	<input type="checkbox"/>	Drug Addictions	<input type="checkbox"/>	HIV/AIDS (Risk or Exposure)	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	Earache	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Sleep Difficulties
<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Kidney Disease/Stones	<input type="checkbox"/>	Street Drug Use
<input type="checkbox"/>	Bowel Changes	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	STDs
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	Marital Problems	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Changing Moles	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Mental Health Disorder	<input type="checkbox"/>	Suicide Attempt
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Thyroid Disease/Problems
<input type="checkbox"/>	Cholesterol (high)	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Tobacco Use/Smoker
<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Tuberculosis (TB)
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Pregnant – Due Date:	<input type="checkbox"/>	Wheezing

Last Pap Smear: _____	Number of Births: _____
Last Mammogram: _____	Birth Control Method: <input type="checkbox"/> None <input type="checkbox"/> Pill <input type="checkbox"/> Condoms <input type="checkbox"/> IUD
Number of Pregnancies: _____	<input type="checkbox"/> Shots <input type="checkbox"/> Tubal <input type="checkbox"/> Vasectomy <input type="checkbox"/> Other _____

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Pharmacy Name and Location: \_\_\_\_\_

Hospitalization/Surgeries: \_\_\_\_\_

COVID-19 Vaccination Dose Number:  None  First Dose  Second Dose  Booster Dose x \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_ Name of Last Eye Doctor: \_\_\_\_\_

Dental Pain  Yes  No, If yes, explain: \_\_\_\_\_

**FAMILY HISTORY**

Check  all that apply to you and your family

<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	High Blood Pressure

To the best of my knowledge, all 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

\_\_\_\_\_  
 Provider Signature Date

\_\_\_\_\_  
 Provider Name (printed)

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 the 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	PHONE NUMBER

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 organization’s web site: [www.pancarefl.org](http://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](http://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. However, PanCare is not set up to make a medical determination as to the cause of an emergent situation that may present and/or occur at any of our clinics. In the event of an emergent situation, our staff will call 911 and defer the advance directive protocol to the acute hospital setting.

## 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 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

- Copy of one (1) paycheck stub from all employed members of the household
- Copy of current year income tax return
- Copy of recent W2 form
- Copy of food stamp eligibility letter
- Proof of benefits/income from social security, disability, unemployment, child support, retirement, etc.

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
PanCare Representative's Verification/Signature

\_\_\_\_\_  
Date