# ACORN Dental Clinic

Name: _____ Date: _____/_____/_____

Sex: M / F Ethnicity: Hispanic / Non-Hispanic Language: _____

Race: (Please Circle one) White African/American Asian Native American

Birth Date: _____/_____/_____ Age:_____ Social Security #: _____

Driver's license #: _____ Veteran Y / N

Address: _____ City, State: _____ Zip:_____
(Street) (Apt. #)

County_____ Medicaid #: _____

Home Phone: (_____) _____ - _____ Work: (_____) _____ - _____ * _____

Cell Phone: (_____) _____ - _____ Email: _____

**Please circle one:** Employed Unemployed Retired Disabled

**How did you hear about ACORN?** Family/Friend Media School Church Outreach Doctor/Dentist Other_____

| | | | |
|---|---|---|---|
| EMERGENCY CONTACT: | | PHONE: | |
| PHYSICIANS NAME: | | PHONE: | |
| PHARMACY: | | PHONE: | |

## SLIDING FEE SCALE APPLICATION

The following information is based on **all** household members

| | | | |
|---|---|---|---|
| TOTAL # of ADULTS | | TOTAL # of CHILDREN | |

| SOURCE | SELF | SPOUSE | OTHER | TOTAL |
|---|---|---|---|---|
| Net Wages, Salaries, Tips, Prior Year Tax Return | | | | |
| Income from Business, self-employment and dependents | | | | |
| Unemployment, Workers Comp, Social Security, Public Assistance, Veteran's Payments, Survivor benefits, Pension or Retirement Compensation | | | | |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside household and/or miscellaneous sources | | | | |

Note: Copies of prior year tax returns, three most recent pay stubs or other information verifying income is required before discount is approved. I certify that the family size and income information shown above is correct.

Signature:_____ Date: _____

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(Circle **Y** or **N** to indicate if you have ever had any of the following):

| | | | | | |
|---|---|---|---|---|---|
| Acid Reflux / GERD | **Y** | **N** | High Blood Pressure | **Y** | **N** |
| AIDS / HIV | **Y** | **N** | Jaundice | **Y** | **N** |
| Alcohol Dependency | **Y** | **N** | Kidney Disease | **Y** | **N** |
| Anemia | **Y** | **N** | Liver Disease | **Y** | **N** |
| Arthritis, Rheumatism | **Y** | **N** | Mental Disorders/Psychiatric Care | **Y** | **N** |
| Artificial Heart Valves | **Y** | **N** | Mouth Sores | **Y** | **N** |
| Artificial Joint | **Y** | **N** | Nervous Disorders | **Y** | **N** |
| Asthma | **Y** | **N** | Nursing Mother | **Y** | **N** |
| Bleeding Abnormally / Excessive | **Y** | **N** | Pacemaker | **Y** | **N** |
| Bleeding gums | **Y** | **N** | Past Surgeries | **Y** | **N** |
| Blood Disease | **Y** | **N** | **when & type:** | | |
| Cancer | **Y** | **N** | Pregnant (currently) **due date:**_____ | **Y** | **N** |
| **when & type:** | | | Radiation Therapy | **Y** | **N** |
| Chemical/Drug Dependency | **Y** | **N** | Respiratory Disease | **Y** | **N** |
| Chemotherapy | **Y** | **N** | Rheumatic Fever | **Y** | **N** |
| Clenching, Grinding, Jaw Popping | **Y** | **N** | Seasonal Allergies | **Y** | **N** |
| COPD/Emphysema | **Y** | **N** | Shortness of Breath | **Y** | **N** |
| Diabetes | **Y** | **N** | Sinus Trouble | **Y** | **N** |
| Dry Mouth | **Y** | **N** | Sleep Apnea | **Y** | **N** |
| Epilepsy | **Y** | **N** | Stroke **Year:** _____ | **Y** | **N** |
| Fainting/Dizziness | **Y** | **N** | Swollen feet and ankles | **Y** | **N** |
| Head/Neck/Back Injury | **Y** | **N** | Teeth Sensitivity | **Y** | **N** |
| which: | | | Thyroid Problems | **Y** | **N** |
| Heart Attack **Year:**_____ | **Y** | **N** | Tobacco Use/Smoker | **Y** | **N** |
| Heart Disease | **Y** | **N** | Tuberculosis | **Y** | **N** |
| Heart Murmur | **Y** | **N** | Tumor | **Y** | **N** |
| Hepatitis, **type**: | **Y** | **N** | **when & type:** | | |
| Herpes | **Y** | **N** | Ulcer | **Y** | **N** |
| Other: | | | Venereal Disease | **Y** | **N** |

**When was your last dental visit?** _____

**List any medication allergies:** _____

**List all medications you are currently taking:** **Are you taking birth control? Y/N**

_____

_____

Have you ever been told to take medication before a dental procedure? **Y** / **N** Type: _____

Are you taking or have you ever taken medication for **bone density**? _____

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I certify that the above medical information is correct.

Signature:_____ Date: _____

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**ACKNOWLEDGE OF REVIEW OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice of Privacy Practices. You may refuse to sign this acknowledge, if you wish.

I acknowledge that I have reviewed a copy of the office's Notice of Privacy Practices.

_____ _____

Signature Date

# ACORN DENTAL CLINIC PATIENT AGREEMENT

ACORN Clinic **(352) 485-2772,** is a private, non-profit agency. We are not government operated. Our mission is to make dental care affordable to as many people as possible. We offer patients reduced fees due to agreements with **UF College of Dentistry, SFC Hygiene Program**, and **volunteer dentists.** A dentist always supervises students. **ACORN Clinic and its grounds are smoke-free.**

***APPOINTMENTS*** Please do not bring small children to leave unattended. **Minors/children must have a parent or guardian present.**

Cleanings must be completed and current before fillings, crowns and partials will be done.
**We must have a confirmation to hold your appointment.** We call everyone before their appointment. If we do not hear from you, we cancel your appointment to allow someone else to take the appointment. If you are hard to reach or do not have a phone, etc. **you must call us. You must give 24 hour notice for cancelling. Patients are allowed one Noshow, and will be discharged after second Noshow.**

***EMERGENCY APPOINTMENTS*** We do not have clinic everyday. We will do our best to get our patients in on an emergency basis.

***FEES*** The Dental Clinic has a sliding fee scale. **You must bring verification of income at your first appointment and at first of new year.** New patients are required to pay a $100.00 fee before being seen. We must receive complete payment for services delivered **before** you can be scheduled for another appointment. We accept Medicaid, not private insurance.

***DISCHARGE***
**ACORN reserves the right to discharge a patient whose behavior or communication is disrespectful, offensive, or socially inappropriate.**
ACORN reserves the right to discharge a patient if the patient does not participate in their own oral health care needs. We can help you, but you must also agree to take care of your teeth at home. Sometimes this also includes changes in lifestyle or diet.
We may refer patients out when we believe the treatment is beyond our scope of care, the treatment is too difficult for our student dentists or hygienists, or the patient requires so much care that they would be better served in a private dental office or hospital setting.

***THANK YOU***
Please remember to **give thanks** to the people who volunteer their time to provide your health care needs.. We care about our patients and want to continue to serve you in the best way possible. Please treat us with the same respect we treat you. **I understand and agree to the terms of this agreement.**

_____ _____

Signature Date