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:** Discounts are offered based on family size and income. A family is defined as a group of two or more people related by birth, marriage, adoption and/or living together. The residence to be considered in establishing family size will be the location of the collective family**. Household income must include self, spouse, dependents over 18 and any other household members over the age of 18**. Sources of income include, but are not limited to:

☐ 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

You may be asked to provide additional income information.

- **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.
- We currently have a wait list for new comprehensive appointments. It may be months before we get you scheduled. Your eligibility will still be valid for emergency visits and will need to be updated yearly.

If you have any questions regarding this application before turning it in, please email us at: SulzbacherDental@SulzbacherJax.org

Please bring all of your supporting documents and a photo ID.

Clinic locations:

- Downtown: 611 E. Adams Street, 32202 (904) 394-8060
- 5455 Springfield Blvd, 32208 (904) 394-4963

Duval Family HEALTH CENTER

PATIENT REGISTRATION FORM

Chosen Name:		
Legal Name (first, middle, last):		
Address:		
City:	State:	Zip:
Date of Birth:	Social Security #:	
Cell or Other:	E-mail address:	

How did you hear about our clinic:

Number of individuals/family members living in household:	
Name of Emergency Contact:	
Relationship:	Contact Number:

Please select your Race	Mark with an X	Please select Ethnicity	Mark with an X
Asian Indian		Mexican, Mexican American, Chicano	
Chinese		Puerto Rican	
Filipino		Cuban	
Japanese		Another Hispanic, Latino/a, or Spanish Origin	
Korean		Hispanic, Latino/a, Spanish Origin, combined	
Vietnamese		Not Hispanic	
Other Asian		Chose not to disclose	
Native Hawaiian		**Gender Identity**	**Mark with an X**
Other Pacific Islander		Male	
Guamanian or Chamorro		Female	
Samoan		Chose not to disclose	
Black/African American		**Residence Status**	
American Indian/Alaska Native		US Citizen	
White		**Veteran Status**	
More than one race		Yes	
Chose not to disclose		No	

Current Insurance:

Are you currently homeless? ☐ Yes ☐ No

Have you been homeless in the last 12 months? ☐ No ☐ Yes, please check all that apply below

☐ Lived in homeless shelter ☐ Lived in transitional housing or treatment center ☐ Evicted

☐ Lived on street or in car, park, sidewalk, or abandoned building ☐ Temporarily living with another family member or friend

By signing this document, I confirm that this information correctly describes my 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 Clinic to give treatment, perform tests to treat me or find out what is wrong, take blood samples for lab tests ordered by the provider (including HIV test), allow medical/nursing/dental students/residents/interns to help the provider with my care, and allow providers to obtain medication history information.

Printed Patient Name: (or Legal Guardian)		**Date:**
Patient Signature: (or Legal Guardian)		**Date:**

Duval Family HEALTH CENTER

Disclosure of Protected Health Information and Privacy Authorization Form

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip Code

SSN#: _____ Date of Birth: _____ Tel. No: _____

1. Disclosure of Health Information for Treatment, Payment & Healthcare Operations

I consent to the use and disclosure of my protected health information for treatment, billing, and healthcare operations. I have been given 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 my clinical information.
- The right to request to amend clinical information I feel is incorrect or incomplete.
- The right to request that Sulzbacher restricts its use and disclosure of my 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, _____, have read this consent form and the Notice of Privacy Practices. I understand that I am giving you consent to use and disclose my health information for treatment, billing, and healthcare operations.

_____ _____
Signature of Patient/Legal Guardian Date

2. HIPAA Privacy Authorization

Who can see my health information? Please list any family members or others who may be involved in coordinating your care.

Name	Address	Relationship to Patient

How long can they see my information?

☐ From _____ to _____

☐ All past, present, and future periods

What can they see?

☐ Everything

☐ Everything EXCEPT the following (check all that apply)

- ☐ Mental health records
- ☐ HIV/AIDS/Other communicable diseases
- ☐ Alcohol /drug abuse treatment
- ☐ Other, specify: _____

This medical information may be used by the person I authorize for medical treatment, billing or claims, discussions about my 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 Guardian Date

Duval Family HEALTH CENTER

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, my insurance carrier, or other dental entity. A copy of this authorization will be sent to the Health Care Financing Administration, 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 the clinic 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

Duval Family HEALTH CENTER

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 sources. 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 the 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 planning, periodontal surgery, and tooth extraction. I understand that I must follow through with homecare 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 I am being provided this treatment at a low cost to me and the only way that the Sulzbacher Center 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): _____

Patient/Legal Guardian Signature: _____ Date: _____

Duval Family HEALTH CENTER

Oral Surgery and Dental Extractions Informed Consent

I understand that oral surgery and/or dental extractions include inherent risks such as but not limited to the following:

1. Injury to the nerves: This would include injuries causing numbness of the lips, the tongue, and any tissues of the mouth and/or cheeks or face. The numbness which could occur may be a temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.

2. Bleeding, bruising, and swelling: Some moderate bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Swelling usually starts to subside after about 48 hours. Bruises may persist for a week or so.

3. Dry socket: This occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful if not treated. These usually develop 3-4 days after the surgery.

4. Sinus Involvement: In some cases, the root tips of the upper teeth lie in close proximity to sinuses. Occasionally during the extraction or surgical procedures, the sinus membrane may be perforated. Should this occur, it may be necessary to have the sinus surgically closed. Root tips may need to be retrieved from the sinus.

5. Infection: No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile oral environment, for infections to occur post-operatively. These may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, professional attention should be received as soon as possible.

6. Fractured Jaw, Roots, Bone fragments, or Instruments: Although extreme care will be used, the jaw, teeth roots, bone spicules, or instruments used in the extraction procedure may fracture or be fractured requiring retrieval and possibly referral to a specialist. A decision may be made to leave a small piece of root, bone fragment, or instrument in the jaw when removal may require additional extensive surgery, which could cause more harm and add to the risk of complications.

7. Injury to Adjacent Teeth or Fillings: This could occur at times no matter how carefully surgical and/or extraction procedures are performed.

8. Bacterial Endocarditis: Because of normal existence of bacteria in the oral cavity, the tissues of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and Bacteria Endocarditis (an infection of the heart) could occur. It is my responsibility to inform the dentist of any heart problems known or suspected or of any artificial joints I may have.

9. Unusual Reactions to Medications Given or Prescribed: Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics can render the contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.

******* It is my responsibility to seek attention should any undue circumstances occur post-operatively and I shall diligently follow any pre-operative instructions given to me.

Informed Consent

As a patient, I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fees for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Sulzbacher dentists and/or volunteers to render any treatments necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Name of Patient_____

Signature of Patient and Date_____

Signature of Staff and Date_____

January 2026

Duval Family
HEALTH CENTER

MEDICAL HISTORY

Name _____ DOB _____

Date _____ Date of Last **Dental** Exam_____

Current Pharmacy: _____

Please circle Yes or No for the questions below (If yes, please provide details)

Yes No Are you currently under a physician's care? If yes, nature of care: _____

Yes No Have you ever had a serious head, neck, or back injury? _____

Yes No Do you/have you ever used controlled substances? If yes, please list type: _____

How long since you last used? _____ Type of substance: _____

Yes No Do you/have you ever consumed alcoholic beverages? How often: Daily Weekly Occasionally

Amount: _____Last consumed: _____

Yes No Have you ever taken Fosamax, Boniva, Actonel, Zometa or any other medications containing bisphosphonates? If so, when did the treatment begin? _____

Yes No Have you ever taken Xarelto, Coumadin, Eliquis, Pradaxa, Heparin or any other blood thinners? _____

Do you use any of the following: Cigarettes E-Cigarettes Cigar Hookah Vapor devices
Marijuana Chewing Tobacco

How often do you use: Daily Weekly Occasionally

How long have you been using: _____

Are you allergic to any of the following?

Yes No Local anesthetics or epinephrine

Yes No Aspirin or Ibuprofen

Yes No Tylenol

Yes No Penicillin or other antibiotics

Yes No Codeine, Valium or other sedatives

Yes No Latex or Metals

Yes No Other (please specify) _____

Women:

Yes No Are you pregnant?

Yes No Are you trying to get pregnant?

Yes No Are you taking oral contraceptives?

Yes No Are you nursing?

Are you currently taking any medications? If yes, please list ALL medications below:

_____

_____

Duval Family HEALTH CENTER

Patient Name: _____ **DOB:** _____

Please check all of the conditions that apply:

Cardiovascular		**Respiratory**		**Excretory**		**Infections**	
Angina		COPD (emphysema/bronchitis)		Liver disorder (non-infectious)		Hepatitis A, B, C	
Heart attack Date: _____		Asthma		Kidney stones		HIV/AIDS	
Heart failure		Sinus/Hay fever		Kidney failure		Tuberculosis	
High blood pressure		Obstructive sleep apnea		Bladder disorder			
Low blood pressure		Sinus problems		Dialysis		**Miscellaneous**	
Arrhythmias (irregular beat)						Excessive bleeding	
Congenital heart defect		**Gastrointestinal**		**Nervous**		Arthritis	
Valve disease/murmur		Ulcers		Seizures/Epilepsy		Osteoporosis	
Artificial heart valve		GERD		Depression		Joint replacement: date_____	
Endocarditis (heart infection)		Stomach or intestinal disease		Anxiety/panic attack		Cancer/tumor	
Stroke/TIA Date: _____		Unintentional weight loss/gain		Psychosis/mania		Radiation or chemotherapy	
Bleeding problems		Endocrine		Multiple sclerosis		Sore/enlarged lymph nodes	
Blood cell disorders		Thyroid disease		Headaches/migraine		Biopsy	
High cholesterol		Diabetes mellitus (type I)		Psychiatric disorder		Fainting/dizzy spells	
Transfusion		Diabetes mellitus (type II)		Drug abuse		Tonsillitis	
Coronary heart disease				Alcohol abuse		Slow-healing mouth sores	
				Alzheimer's/dementia		Pain in jaw joint	
				Physical disability		Transplants	
				Cognitive disability			
				PTSD			

Patient Signature _____ **Date** _____

Duval Family HEALTH CENTER