

Mission:
To protect, promote & improve the health
of all people in Florida through integrated
state, county & community efforts.



Rick Scott
Governor

Celeste Philip, MD, MPH
State Surgeon General and Secretary

Vision: To be the Healthiest State in the Nation

Dear Valued Patient Guardian or Parent

We are happy to have you as a client of The Florida Department of Health, Nassau County Dental Clinic. We are devoted to providing the best dental care possible in a timely and courteous manner. As our clients, you can help us achieve this goal in several ways.

1. Be on time for your dental appointment. Please realize that if you are late, it creates a domino effect and will cause the remaining appointments to be compromised. There is a grace period of 10 minutes. After that, we reserve the right to reschedule your appointment.
2. We expect you to come to your scheduled appointments. We are a small clinic and have many patients that need our care. If you are unable to come to your appointment, you must give a 24 hour notice. If you give that notice, there will be no penalty. If you do not come to your appointment or cancel within a 24 hour period, there will be a penalty assessed. You will be reminded of this penalty by phone when you call to reschedule your appointment. **If you have 3 penalties assessed in one calendar year, we will no longer schedule you for regular dental care and you will only be seen for dental emergencies.**
3. We try to call and confirm all appointments the day before as a courtesy to you. If for some reason you do not receive a call, you are still expected to come to your appointment. If your telephone number has been changed, disconnected or you have no phone, please let us know in advance of your appointment.
4. Please let us know in advance if you are not planning to come to your scheduled appointment. No shows are very costly for our clinic and can and should be avoided.

If you have any questions, please let us know. We will be happy to address any questions, comments or concerns you may have.

Please sign and date below, stating you understood and agree to the above requirements.

Patient/Parent or Guardian of Patient Signature

Date