South Tampa SMILES
JOHN CANNARIATO, DMD

Welcome to our practice!

We thank you for choosing our office for your dental needs. Did you know your oral health is a vital part of your overall well being? This is why we take a comprehensive approach when designing a treatment plan for your needs. Some of the services we offer include six month braces for adults, veneers, implants, oral surgery, root canals and teeth whitening, just to name a few. Most procedures can be performed in our office, thus eliminating the need to travel to a different office for specialized treatment.

Throughout the year, my staff and I spend many hours attending continuing education courses to ensure that we are using the latest technology, techniques and resources available. This allows us to provide our patients with care that is not only cutting edge, but also time and cost effective as well. To ensure the highest level of precision in your treatments, we have dental microscopes in each of our operatories. We also have a CEREC machine that makes crowns in our office, which means we no longer need to create temporaries or take impressions and send them to a lab. Because of this, the traditional second visit to have a crown placed can be eliminated.

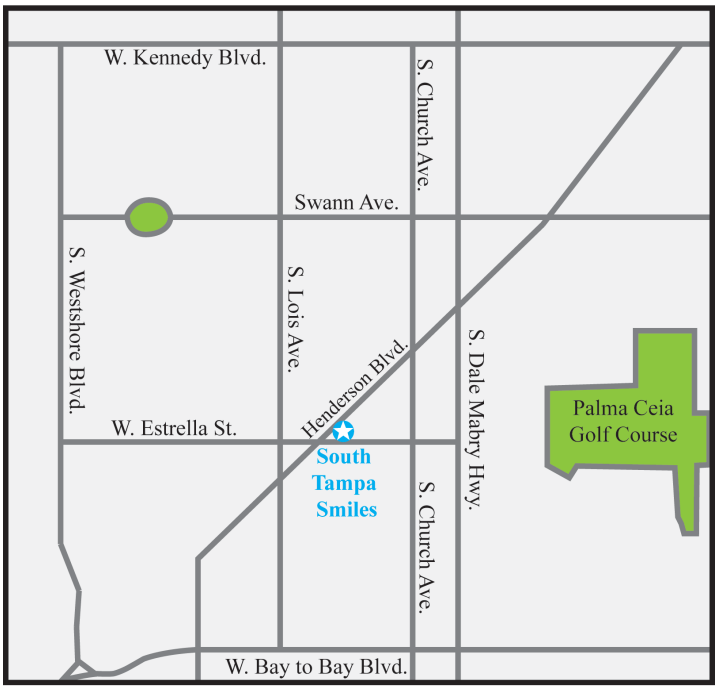
On each and every visit, we will strive to make it a pleasurable experience. For your comfort, we offer treatments chairs with back massagers, televisions in every treatment room and refreshments in our reception area. If there is anything else we can do to makes your visits more pleasant, please let us know.

We thank you for choosing our office and look forward to seeing you soon.

Sincerely,

John M. Cannariato

John M. Cannariato, D.M.D.



We are located on the corner of Henderson and Estrella.

4066 Henderson Blvd. ◆ Tampa, FL ◆ 33629 ◆ (813) 289-0560 ◆ www.SouthTampaSmiles.com

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JOHN CANNARIATO, DMD

Commonly Asked Questions

Q. Going to the dentist makes me anxious. Is there anything you can do to make me feel more comfortable?
A. This is a common problem that many patients face and will often prevent them from receiving much needed treatment, which will only result in additional problems later on. Dr. Cannariato will take ample time to explain the procedure, answer any questions you may have and make you feel at ease. For many patients, just knowing what to expect helps them to relax. For patients needing something additional, we do offer nitrous oxide, often referred to as laughing gas, to help you feel more comfortable. If necessary, we may also prescribe an oral sedative to be taken prior to your appointment.

Q. Do you offer payment plans?
A. We realize dental treatment can be costly, especially for patients without insurance coverage. While we do not offer in house financing, we do to participate in the CareCredit program. CareCredit is a fantastic option for patients who are looking to make payments on a monthly basis. There are several different options including 0% interest financing for up to 12 months.

Q. I would love to have my teeth whitened, but isn't it expensive?
A. Dr. Cannariato has chosen to offer a variety of whitening options to make it affordable for all our patients. We have whitening systems for as low as $65.

Q. Do you take my insurance?
A. We are able to work with most insurance policies. Please call our office with your insurance information and we will gladly contact your insurance carrier to verify your benefits.

Q. Why are x-rays necessary and aren't they harmful?
A. X-rays are a vital tool in diagnosing common oral problems such as cavities, periodontal disease, abscesses and an array of other issues. Because many oral problems reside beneath the gums, between the teeth and under existing dental work, x-rays allow us to see what a visual exam does not. Just as your medical doctor orders yearly tests, we require yearly x-rays to give you a clean bill of oral health. Our office uses the latest technology in digital imaging to minimize any apparent exposure. The American Dental Association has performed countless research concluding that the radiation received from digital dental x-rays is far less than what people receive on a daily basis from naturally occurring elements.

As a courtesy, we will call you to remind you of the appointment which you have scheduled. We realize that your time is very valuable and do our best to minimize wait times. In return, we ask if you are unable to keep a scheduled appointment, you notify the office so we may offer our services to another patient in need. Appointments cancelled or missed with less than 24 hours notice may be subject to a fee.

Dr. Cannariato is committed to providing his patients with the best care and staying up to date on current advancements to improve our quality of care.

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JOHN CANNARIATO, DMD

Financial Policy

Please read and sign below.

As a courtesy to our patients, our office is happy to file your dental insurance for you and wait up to **30 days** for payment from them. If you prefer, we will collect the full amount due directly from you at the time of service and bill the insurance company for payment to go directly to you.

If you choose to have us wait for your insurance payment, we will collect the amount we **estimate** will be due from you at the time of service. Though we strive to be accurate, this is only an **estimate** and a balance may be due after insurance has paid their portion. After **30 days** or upon payment from your insurance company, the balance becomes due and payable in full by you. If a problem arises with the claim, we will continue to do whatever is necessary to see that you are reimbursed any amount still due to you from the insurance company.

Failure to pay your balance within 30 days may result in a late fee of $25.00

I have read the agreement above and understand the terms. I choose to have payment paid to the provider of service.

_____

Signature

I choose to pay the full amount due at time of service and have any payment from the insurance company come directly to me.

_____

Signature

South Tampa SMILES
JOHN CANNARIATO, DMD

Notice of Privacy Practices of Dr. John Cannariato, D.M.D.

A new law requires us to maintain your privacy, to give you this notice and to follow the terms of this notice. This notice describes how your health information may be used, disclosed and how you can access this information. Please review it carefully.

The law permits us to disclose your health information to those involved in your treatment. For example, a review of your file by a specialist whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, if you have insurance, we may send a report of your progress to your insurance company. We may also share information with our business associates, such as a billing service. We will have a written contract with each business associate that requires them to protect your privacy. All records containing health or personal information will be shredded if no longer needed and all such retained information will be kept secure.

We may use or disclose your information to contact you. For example, we may send you newsletter or other information. We will also call to confirm the time and day we have reserved for your dental care. If you are not home, we may leave this information on your answering machine or with the person who answers the phone. We may need to contact you from time to time. We will use whatever address and telephone number you prefer.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. We will need a signed request for the transfer. A reasonable fee may apply.

You have the right to see and receive a copy of your health information, with a few exceptions, in a timely manner without delays for legal review. Please give us a written request regarding the information you would like to see. If you also would like a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Please give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW Room 509 F, Washington, DC, 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Dr. John Cannariato.

Acknowledgement

I have received a copy of the Privacy Practices Notice of Dr. John Cannariato, D.M.D.

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient. _____

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JOHN CANNARIATO, DMD

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments or fees, please feel free to ask. This Acquaintance Form will help us to serve you better.

PLEASE PRINT

DATE: _____ EMAIL ADDRESS: _____

PATIENT'S NAME: _____

MARITIAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

SPOUSE'S NAME: _____

PATIENT'S ADDRESS: _____ ZIP: _____

PHONE: _____|_____|_____|_____
Home Work Cell Preferred

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY # _____

EMPLOYED BY: _____

BUSINESS ADDRESS: _____

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO NAME OF INSURANCE CO.: _____

POLICY HOLDER: _____ SOCIAL SECURITY # OF POLICY HOLDER: _____

DATE OF BIRTH OF POLICY HOLDER: _____/_____/_____

EMPLOYED BY: _____ BUSINESS ADDRESS: _____

IF PATIENT IS A CHILD, PARENT OR LEGAL GUARDIAN NAME: _____

PURPOSE OF VISIT: _____ FORMER DENTIST: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

IF REFERRED BY ANOTHER PATIENT, WHOM MAY WE THANK FOR REFERRING YOU? _____

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? _____

NAME: _____ EMERGENCY CONTACT: _____

PHONE: _____ ADDRESS: _____

AUTHORIZATION TO RELEASE INFORMATION AND X-RAYS RELATING TO MY TREATMENT:

Signature: _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST:

Signature: _____

South Tampa SMILES
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HEALTH HISTORY

1. Are you currently under the care of a physician? ☐ Yes ☐ No
2. Physician's full name: _____
   Address: _____ Phone: _____
3. Please list all medications, drugs and pills you are currently taking, including dosage and the frequency of each: _____
   _____
4. Have you had any serious illness or hospitalization within the past five years? _____
5. Are you allergic or have you reacted adversely to any of the following medications? (Please circle if yes)

Aspirin	Ibuprofen	Penicillin	Other Antibiotics
Codeine	Local Anesthetic	Tetracycline	
Dolobid	Latex	Valium	
Erythromycin	Novocain	Xylocaine	

6. Are you aware of being allergic to any other medication or substance? _____
   Please list: _____
7. Have you ever had: (Please circle if yes)

Abnormal blood pressure	Hepatitis
AIDS	Jaundice
Allergies	Kidney disease
Angina	Liver disease
Arthritis	Mitral valve prolapse
Artificial heart valves	Organ transplant
Artificial joints	Pacemaker
Asthma	Polio
Blood transfusion	Prolonged bleeding
Cancer	Prolonged cough
Chemotherapy	Psychiatric treatment
Congenital heart lesions	Radiation therapy
Diabetes	Rheumatic fever
Drug dependency	Sexually transmitted disease
Epilepsy	Sickle cell anemia
Fainting	Stroke
Glaucoma	Thyroid disease
Heart disease	Tuberculosis
Herpes	Ulcers
HIV	Dental implants
Herbs or Minerals	Diet supplements
Heart murmur	

Do you have any disease, condition or problem not previously listed?
_____

8. Do you smoke? ☐ Yes ☐ No If yes, how much? _____

WOMEN:

9. Are you pregnant? ☐ Yes ☐ No If so, what month? _____
10. Are you nursing? ☐ Yes ☐ No Are you taking hormones? ☐ Yes ☐ No
11. Are you taking birth control pills? ☐ Yes ☐ No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

SIGNATURE **DATE**

South Tampa SMILES
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DENTAL HISTORY

1. Are you having any discomfort at this time? _____
2. What concerns you the most? _____
3. When was your last dental visit? _____
4. Do any of the following cause tooth discomfort?
   ☐ HOT ☐ COLD ☐ SWEETS ☐ CHEWING
5. Do you have any sores in or around your mouth? _____
6. Are you aware of any swelling or lumps in your mouth? _____
7. When was your last dental cleaning? _____
8. Do your gums bleed when you brush or floss? _____
9. Have you ever had periodontal (gum) treatments? _____
10. Is there any unpleasant taste or odor in your mouth? _____
11. Which of the following do you use at home on a regular basis?
    Toothbrush: ☐ HARD ☐ MEDIUM ☐ SOFT ☐ ELECTRIC
    ☐ Oral Irrigator (water pik) ☐ Gum massager
    ☐ Floss Other cleaning device: _____
    ☐ Fluoride (other than fluoridated toothpaste) ☐ Mouthwash
    Have either of your parents lost any teeth due to gum disease? ☐ Mother ☐ Father ☐ Both

12.	Do you have any missing teeth?	Yes	No
	Have they been replaced?	Yes	No
	Are you comfortable with the replacements?	Yes	No
13.	Do you have any loose teeth?	Yes	No
14.	Have you ever had orthodontic treatment (braces)?	Yes	No
15.	Do you lose fillings or break fillings?	Yes	No
16.	Do you eat much citrus fruit?	Yes	No
17.	Do you frequently drink soft drinks? (regular/diet)	Yes	No
18.	Do you usually have many cavities?	Yes	No
	Cracked or broken teeth?	Yes	No
19.	Do you have any noticeable wear on your teeth?	Yes	No
	Food traps?	Yes	No
20.	Do you grind or clench your teeth?	Yes	No
21.	Do you have frequent headaches?	Yes	No
22.	Do you have frequent pain in or around your ears?	Yes	No
23.	Does your jaw hurt when you open your mouth wide, yawn or chew?	Yes	No
24.	Do you notice any clicking or grinding noises in your jaw joint?	Yes	No
25.	Does your jaw get "stuck," "locked" or "go out?"	Yes	No
26.	Does your bite feel uncomfortable or unusual?	Yes	No
27.	Have you had any injury to your jaw, head or neck?	Yes	No

28. Have you ever been treated for a temporomandibular disorder? If so, when, what, how and by whom? _____
    _____
    _____

29. Do you like the appearance of your teeth and your smile? ..... Yes No

    If not, what would you like to change the most in the appearance of your teeth? _____
    _____

30. Have you ever had an unpleasant dental experience or are dissatisfied with your past dentistry? Yes No

31. Please add anything else you feel is important? _____
    _____
    _____

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HEALTH HISTORY UPDATE
FOR STAFF USE ONLY

DATE: _____
SIGNATURE: _____
CHANGES: _____

DATE: _____
SIGNATURE: _____
CHANGES: _____

DATE: _____
SIGNATURE: _____
CHANGES: _____

DATE: _____
SIGNATURE: _____
CHANGES: _____

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