PATIENT INFORMATION

South Tampa SMILES

PATIENT'S NAME _____ Today's Date _____
Home Address _____ SSN _____
City, State, Zip _____ Date of Birth _____
Email _____ Home Phone _____
Patient's Employer _____ Work Phone _____
Driver's License # _____ Mobile Phone _____

INSURANCE COMPANY _____ Phone _____
Subscriber Name _____ Date of Birth _____
Employer _____ Work Phone _____
SSN or ID# _____ Group # _____

IF PATIENT IS A MINOR
Parent/Guardian Name _____ Home Phone _____
SSN _____ Date of Birth _____

Are you taking any medications? ☐ **Yes** ☐ **No** **Please List:** _____

MEDICAL HISTORY

Have you ever had? (Check box to the left)

Yes	No		Yes	No	
☐	☐	Heart Murmur/MVP	☐	☐	Migraine/Headaches
☐	☐	Heart Disease	☐	☐	Currently Pregnant/Breastfeeding
☐	☐	Rheumatic Fever	☐	☐	Herpes
☐	☐	High Blood Pressure	☐	☐	Immunocomprised
☐	☐	Liver Disease	☐	☐	Chest Pain
☐	☐	HIV Positive	☐	☐	Radiation/Chemo Therapy
☐	☐	Diabetes	☐	☐	TMJ Problems
☐	☐	Lung Disease/Asthma	☐	☐	Pacemaker
☐	☐	Excessive Bleeding	☐	☐	Prosthetic Implant
☐	☐	Thyroid Problems	☐	☐	Joint Replacement
☐	☐	Hepatitis	☐	☐	Arthritis
☐	☐	Tuberculosis	☐	☐	Heart Attack
☐	☐	Epilepsy	☐	☐	Stroke

Do you have any allergies?

Yes	No		Yes	No		
☐	☐	Aspirin	☐	☐	Codeine	**Please List:** _____
☐	☐	Penicillin	☐	☐	Latex	_____
☐	☐	Local Aneshetic				

Do you have any other medical conditions? _____
Are you under medical treatment now? _____
Have you had surgery in the past five years? _____
Do you premedicate or routinely take antibiotics before dental treatment? ☐ Yes ☐ No
Physician's Name _____ Phone _____
Notify in case of emergency _____ Phone _____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have the opportunity to discuss my health history with the doctors and assistants.

X Signature of responsible party _____ Date _____

South Tampa SMILES

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 you or your insurance company, the balance becomes due and payable in full by you. If a problem arises with the claim or payment, we will continue to do whatever we can for up to **90 days** 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

Our office policy requires 48 hours notice for rescheduling or canceling an appointment. Failure to do so may/will result in a missed appointment fee.

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 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 a 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 you 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.

Acknowledgment

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. _____