CAMILLA SAVARDI, DMD
FAMILY AND COSMETIC DENTISTRY

Confidential Patient Information – I

(Please Print Legibly)

Personal Information

Name (First, Middle, Last): _____ SS #: _____

Address:_____City:_____

State: _____ Zip: _____Telephone: Home _____Work _____

Cell _____E-mail: _____

Birth date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred by: _____

Previous Dentist:_____ Last date of cleaning and exam:_____

Person to Be Contacted in Case of Emergency

Name:_____ Relationship to Patient:_____

Phone:_____ Work:_____

Person Responsible for Account

Name: _____ Relationship: _____ SS #: _____

Address:_____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

Dental Insurance Information

Primary Insurance Co:_____ Phone Number:_____

Insurance Co. Address: _____

Name of Card Holder: _____ Relationship: _____ S.S. #: _____

Date of Birth:_____ Employer: _____ Policy #: _____

We would like to know more about you. Please fill in the following information to help us get to know you better.

Name: _____ Date:_____

Where did you grow up?_____

Do you have children?_____ What are their ages?_____

What is your educational background or degree awarded? _____

What special interests or activities do you enjoy?_____

Is there anything special you would like us to know about you?_____

Is there anything you would like to change around your smile?_____

Confidential Patient Information – II

(Please Print Legibly)

Patient Name: _____ Initial Date:_____

Health Information

Personal Physician Name:_____ Phone Number:_____

Personal Physician Address: _____

YES NO

- ❑ ❑ Have you been hospitalized within the past 2 years? For what? _____
- ❑ ❑ Are you currently being treated by a physician? For what? _____

_____

- ❑ ❑ Are you currently taking any medicines or drugs? What?_____

_____

- ❑ ❑ Are you currently on blood thinners?
- ❑ ❑ Are you currently or have you previously taken bisphosphonates?
- ❑ ❑ Do you or have you taken an Antibiotic before dental treatment (premed)?
- ❑ ❑ Are you allergic to any drugs? What?_____
- ❑ ❑ Have you ever had a reaction to metals? What? _____
- ❑ ❑ Are you allergic to any metals? What?_____
- ❑ ❑ Do you bleed excessively upon injury?_____
- ❑ ❑ Are you pregnant? How many weeks pregnant?_____
- ❑ ❑ Do you have a history of smoking? How long ago?_____
- ❑ ❑ Do you smoke? How often?_____
- ❑ ❑ Have you used recreational drugs in the past?
- ❑ ❑ Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
- ❑ ❑ Have you ever been involved with dental/medical legal activity?
- ❑ ❑ Have you ever had head or neck radiation?

Circle Any of the Following Conditions That You Have Had or Now Have

AIDS	Glaucoma	Low Blood Pressure	Rheumatic Fever
Arthritis	Heart Murmur	Nervous Breakdown	Sexually Transmitted Diseases
Asthma	Heart Problem	Prosthetic Heart Valve	Stroke
Cancer	Hepatitis A/B/C	Psychiatric Therapy	Total Joint Replacement
Diabetes Type I	High Blood Pressure	Osteoarthritis	Tuberculosis
Diabetes Type II	Jaundice	Osteoporosis	

Epilepsy Kidney Problems Rheumatoid Arthritis

Financial Policy

Payment is due at the time service is rendered. We offer a range of financial options that are listed below to help make quality dental care affordable.

- Cash/Check
- All major credit cards
- Care Credit

Financing

We offer dental care financing through Care Credit. Zero interest and low interest plans are available.

Dental Insurance

As a courtesy to our patients, we accept more major dental insurance plans. Please provide us with your card and a photo I.D. so that we may estimate your benefits and file the insurance claim on your behalf. We will always assist you in maximizing your dental benefits. At the time of services you will be responsible for your estimated co-payment cost. However, please be aware that our office can only provide you with an approximation of benefits and it is not a guarantee of payment. Any remaining balance after your insurance has paid is your responsibility.

Cancellation Policy

I understand that I must give at least 24 hours notice prior to the cancellation of an appointment or a broken appointment charge (minimum $50) may be assessed. Actual charges will vary due to the amount of time reserved for my appointment. Emergency or special situations will be considered. I will be responsible for keeping my appointment even if the office is unable to contact me.

Arriving late policy

Our office makes every attempt to remain on schedule throughout the day. We value your time and will do our best to keep you from having go wait. That said, each patient is an individual, and may require more than anticipated. We ask for your patience and that you keep in mind that you may be the next one needing a little extra attention.

Late arrivals cause schedule delays for those patients who arrive promptly to their appointment time. Specifically for hygiene appointments, late arrivals of 15 minutes or more will need to be reschedule. For other appointments, it may be possible to be worked into the schedule.

Return check fee

Checks returned to our office from your financial institution are subject to a $30 return check fee. This fee covers the processing fees that are charged to our office.

Print name:_____Date:_____

Signature:_____

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the more current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____, 20_____.

Printed Patient Name:_____

Relationship to patient:_____

Signature:_____

Practice Name: Camilla Savardi, DMD
Address: 210 John Knox Road
City/State/Zip: Tallahassee, FL 32303