A GLAMOROUS SMILE
James Annicchiarico, DDS

2027 Little Road, Trinity, Fl 34655
Phone: 727-834-8885 Fax: 727-372-9455
Email: smilemakeovers@outlook.com

Today's Date: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Social Security Number: _____ Occupation: _____

Phone Number: _____ Email Address: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Whom may we thank for referring you? Family / Friend Name: _____

Referral Source: Mailer / Internet / Insurance / Sign / Other (Please, specify): _____

Do you have dental insurance? Yes No Name of Insurance Company: _____

Medical History

Have you been under the care of a medical doctor during the past **two** years? Yes No

Physician Name: _____ Physician Phone: _____

Have you been hospitalized or had surgery within the past **five** years? Yes No

Explanation: _____

Residual cardiac defects after repair? Yes No

Artificial heart valves? Yes No

History of infective endocarditis? Yes No

Cardiac transplant, valvular heart diseases, or cardiac valvulopathies? Yes No

Unrepaired/incompletely repaired cyanotic congenital heart disease? Yes No

Cardiac defects repaired with prosthetic material or devices? Yes No

Have you had an orthopedic total joint (hip, knee, shoulder) replacement? Yes No

Date of replacement surgery: _____

Do you have any of the following? Please, mark all that apply:

❑ Bacterial Endocarditis	❑ Artificial Heart Valve	❑ Mitral Valve Prolapse	❑ Heart Attack
❑ Heart Disease	❑ Pacemaker	❑ Defibrillator	❑ Angina Pectoris
❑ Rheumatic Fever	❑ Heart Murmur	❑ Stroke	❑ Congenital Heart Lesion
❑ Stents	❑ Shunts	❑ Low Blood Pressure	❑ High Blood Pressure
❑ Hypo Thyroid	❑ Hyper Thyroid	❑ High Cholesterol	❑ Artificial Joints Type:
❑ Epilepsy	❑ Seizures	❑ Fainting spells	❑ Dizzy spells
❑ Anemia	❑ Hemophilia	❑ Bleeding Disorder Type:	❑ Sickle Cell Disease
❑ Tuberculosis	❑ Chronic Bronchitis	❑ Emphysema	❑ Asthma
❑ Arthritis	❑ Osteoporosis	❑ Kidney Disorder	❑ Liver Disorder
❑ Stomach Disease	❑ GERD	❑ Sleep Apnea / CPAP user	❑ Diabetes Type:
❑ Cancer Type:	❑ Radiation Treatment	❑ Chemotherapy	❑ Tumor Type:
❑ Alzheimer's	❑ Dementia	❑ Hepatitis Type:	❑ HIV / AIDS
❑ Cold Sores/ Ulcers	❑ Dental Phobia	❑ Anxiety	❑ Depression
❑ Learning Disability Type:	❑ Substance Abuse Type:	❑ Sexually Transmitted Disease Type:	❑ Mental Disorder Type:

Do you have any diseases, conditions, or problems not listed? Yes No

Explanation: _____

Are you taking an antiresorptive agent (Bisphosphonates)? Yes No

Any known allergies? Yes No Explanation: _____

Are you a tobacco user? Yes No How Long: _____ Type: _____

Any special diet? Yes No Explanation: _____

Women only: Is there a possibility of pregnancy? Yes No Due Date: _____

List of Medications

Medication:	Reason:

Pharmacy Name & Location: _____
Pharmacy Phone Number: _____

Dental History

What is the reason for your dental visit today? _____

When was your last dental visit? _____ What was the appointment for? _____

Date of last dental x-rays: _____ Date of last dental cleaning: _____

Are any of your teeth sensitive to hot, cold, sweet, or pressure? Explain: _____

Do you have trouble with previous dental treatment? Yes No Explain: _____

Any problems associated with your jaw joints (TMJ)? Yes No Explain: _____

Do you clench or grind your teeth? Yes No

Do your gums bleed when you brush or floss? Yes No

Do you wear removable dentures or partials? Yes No

Do you have dental implants? Yes No Date implants placed: _____

Do you like your smile? Yes No Explain: _____

Do you want to discuss options to straighten your smile? Yes No

Do you want to discuss whitening options to brighten your smile? Yes No

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ **Date**: _____

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Informed Consent for General Dental Services

You, the patient, have the right to accept or reject the dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended dental procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre-and post-operative treatment instructions, referrals to other dentists or specialists, and return for schedule appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

You, the patient, understand that you are entering into a contractual relationship with the dentist for professional care. You understand that meritless and frivolous claims of dental malpractice have an adverse effect on the cost and availability of dental care and may result in irreparable harm to a dental provider. As additional considerations for professional care provided to you by the dentist, I, the patient agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of dental malpractice against the dentist and dental staff. I also hold harmless, A Glamorous Smile from any claims arising from associates, specialists, independent contractors or staff. Dr. Annicchiarico and staff shall not be held vicariously liable for claims, disputes or neglect of other providers.

In an effort to control the increasing cost of dental care, any claims or disputes against the office shall be resolved by "binding arbitration". By signing this agreement, the patient agrees with A Glamorous Smile that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, and care of the patient, include the scope of this arbitration clause in the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories of the agreement. Including associates, specialist, and independent contractors) shall be resolved by binding arbitration governed by the provisions of Florida Arbitration code, Florida statutes, section 682.01 et seq. All substantive provisions of Florida law governing medical/dental malpractice claims and damages related to thereto, including but not limited to, the Florida Wrongful Death Act, the standard of care for dental providers, caps on damages under Florida statute 766.118, the applicable statute of limitations and response as well as in the application of collateral sources and setoffs shall be applied.

Venue for the arbitration shall be held in the county where the dental services that are subject to arbitration were rendered. Any party to this agreement, who refuses to go forward with the arbitration, here by acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite the party' absence of the arbitration hearing. The patient understands that the result of this arbitration agreement is that claims, including the malpractice claim that he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved and just as described in the section.

The form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and excepted each paragraph stated above. Be certain all the concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Print Name _____

Patient Signature _____ Date _____

James Annicchiarico, DDS

HIPAA Privacy Notice of Consent

The entire team at Dr. James Annicchiarico's office believes our patients have the right to privacy and that their personal, financial, and health information should be kept confidential.

How do we use your personal health information?

We will use your personal health information to provide, coordinate, or manage your dental treatment and any related services. This may include providing necessary information to pharmacy personnel, laboratory technicians, or third-party healthcare providers. For example, we might need to disclose information, as necessary, to a physician or dental specialist to whom you have been referred to ensure that they have the necessary information to diagnose or treat you. Personal information may be given to your insurance company if necessary to facilitate payment of your claims. On occasion, your personal information may be used for supporting this practice's business operations. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing, and conducting other business activities. We may call you by your name in the reception area when ready to bring you back. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may also use or disclose your personal information in the following situations without your authorization as required by law: public health issues/communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroner's request, research, criminal activity, national security, workers compensation. Other permitted and required uses and disclosures will be made only with your consent, authorization, and opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

What are your rights?

You have the right to inspect and copy your personal information. You have the right to request to receive confidential communications from us by an alternative means or an alternative location. You may have the right to have your dentist amend your personal health information. You have the right to receive an accounting of certain disclosures we have made, if any, of your personal information. You have the right to request a restriction of your personal information. Your request may state that specific restrictions requested, in writing, and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit the use and disclosure of such information, it will not be restricted. You then have the right to seek another health care professional. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have an objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You can be assured there will be no ill will following a complaint by you.

I authorize the following person(s) to receive information regarding my treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This is to verify that I have read and understand the above information. By signing the statement, I have given the team at Dr. Annicchiarico's office permission to release my personal information as described above.

Signature: _____ Date: _____

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Financial Responsibility Policy

As a result of the many different and confusing insurance company reimbursement policies, it is necessary to have an easily understood financial responsibility policy. It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service, at each office visit we need you to show us your insurance card to ensure that your current insurance information is on file.

As a service to our patients, we will submit your insurance claim to your primary insurance company as long as we are in-network. Our office will provide the insurance company with all the information necessary to help you receive the maximum benefit of your insurance. However, it is the patient's responsibility to know the insurance coverage and benefits limits to their particular policy. Please be aware most insurance plans have a maximum amount of benefits that they will pay per plan year. If a claim is denied, we will research while the rejection occurred and either resubmit to insurance or bill you for the appropriate balance. If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient or the responsible party and should be paid to us directly. You may then contact your insurance company for reimbursement.

If the patient has coverage with a secondary insurance company, we will submit all secondary claims directly to that insurance company along with a copy of the explanation of benefits from the primary insurance. Benefits of the secondary insurance coverage may be paid directly to the patient. Insurance is a patient's benefit designed to assist the patient in their financial obligations to the office of Dr. James Annicchiarico. The patient is the one receiving the dental service and therefore ultimately responsible for all charges on the account regardless of any insurance coverage. This applies to everyone in the family who is treated in the office of Dr. James Annichiarico. At the time of service, the office will estimate the anticipated insurance payment and will collect the estimated balance along with your deductible. After the primary insurance payment is received, the patient will be billed for any difference between the estimated balance due in the actual balance due. If the insurance payment is greater than what was anticipated, we will either refund the amount to the patient or leave the credit balance on the patient's accounts we applied towards future treatment.

In the event that the person does not have insurance coverage or the patient's insurance company sends payment directly to them, charges for the services are due and payable at the time services are rendered, unless a signed financial agreement has been approved. Insurance benefits are estimates only. I understand that I am responsible for any copayments and deductibles, along with any procedures that my insurance company does not cover. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third-party payers and or health practitioners. I authorize and request my insurance company to pay directly to the treating dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents. I am also responsible for any balance due because of insurance claims not paid within 60 days of service.

Signature: _____ Date: _____