My Harmony Dentistry , 559 West Twincourt Trail, #606, St Augustine, Fl 32095 904-671-6977

Patient's	Tell Us About Yourself
Name:	
Sex:	☐ Male ☐Female
Date of Birth:	____/____/____ Age: _____
Today's Date:	
Home Phone:	
Home Address:	
City, State, Zipcode:	
Status:	☐ Single ☐ Married ☐ Separated ☐ Widowed
Your Employer:	
How Long Employed:	
Social Security #:	Only required if you have no member ID on dental insurance
Work Phone:	
Are you a full time student?	☐Yes ☐No
Person Responsible for Account:	
Name of Spouse (Parent if Minor):	
Patient Email Address:	
Patient Cell Phone:	
Emergency Info:	Name, Address & Telephone #
How did you hear about our office?	Google? Yelp? Facebook? Website? Instagram? Patient? (please circle) Other _____

DENTAL INSURANCE INFORMATION			
Primary Carrier		Secondary Insurance	
Primary Insured's Name:		PrimaryInsured's Name:	
Date of Birth:		Date of Birth:	
Social Security #:		Social Security #:	
Insured's Employer:		Insured's Employer:	
Insurance Company:		Insurance Company:	
Insurance Co. Address:		Insurance Co. Address:	
Insurance Phone #:		Insurance Phone #:	
Insurance Group #:		Insurance Group #:	
Insurance ID#:		Insurance ID#:	

TELL US ABOUT YOUR TEETH & DENTISTRY

Are you experiencing any of the following:

- Tooth Sensitivity (hot, cold, sweet) ☐
- Where: UR LR UL LL ☐
- Headaches, earaches, neck pain ☐
- Jaw joint pain ☐
- Teeth or fillings breaking ☐
- Grinding or clenching teeth ☐
- Bleeding, swollen or irritated gums ☐
- Loose, tipped or shifting teeth ☐
- Bad Breath ☐

If you could change your smile, would you…?

- Make them whiter? ☐
- Make them straighter? ☐
- Close Spaces? ☐
- Repair chipped teeth? ☐
- Replace missing teeth? ☐
- Replace old crowns that don't match? ☐
- Replace black metal fillings? ☐
- Have a smile makeover? ☐

Do you have or have you had any of the following?

- Dentures ☐
- Partial Dentures ☐
- Braces ☐
- Periodontal (Gum) Treatment ☐

Date of Last Cleaning:
Date of Last Oral Cancer Screening:
Date of Your Last Complete X-Rays:
Name of Last Dentist:
Phone & Address of Last Dentist:
Why did you leave your previous dentist?
Did you smoke or use chewing tobacco?
How much: How long:

On a scale from 1 -10 (10 being the highest):

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

How do you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

What can we do to make your experience here as pleasant and stress-free as possible?
What is the most important thing to you about your dental visit today?
What is the most important thing to you about your future smile and dental health?

MEDICAL HISTORY

Patient Name:

Please check the boxes of the following which apply to you:

☐ Anemia	☐ Stroke	☐ Jaw Joint Pain	☐ Stomach Problems
☐ Bruise/Bleed Easily	☐ Rheumatic Fever	☐ Kidney Disease	☐ Ulcers
☐ Blood Disease	☐ Mitral Valve Prolapse	☐ Liver Disease	☐ Diabetes
☐ AIDS or HIV	☐ Pacemaker	☐ Jaundice	☐ Currently Pregnant
☐ Hepatitis A	☐ Artificial Heart Valve	☐ Lupus/other Autoimmune	☐ Currently Nursing
☐ Hepatitis B	☐ Scarlet Fever	☐ Multiple Sclerosis	☐ Thyroid Disease
☐ Hepatitis C	☐ Bone Density	☐ Seizures	☐ Venereal Diseases
☐ High Blood Pressure	☐ Osteoporosis	☐ Nervousness/Depression	☐ Glaucoma
☐ Low Blood Pressure	☐ Arthritis	☐ Asthma	☐ Drug Addiction
☐ Dizziness/Fainting	☐ Artificial Joints	☐ Tuberculosis	☐ Other:
☐ Heart Conditions	☐ Rheumatism	☐ Allergies (Seasonal)	☐ Other:
☐ Heart Attack	☐ Cancer	☐ Respiratory Problems	☐ Other:
☐ Heart Murmur	☐ Chemotherapy	☐ Emphysema	☐ Other:
☐ Heart Surgery	☐ Radiation(Head/Neck)	☐ Tobacco Habit	☐ Other:

PLEASE LIST ALL ALLERGIES:(ANY DRUGS, MEDICATIONS,LATEX,FOODS, METALS, JEWELRY,PLASTICS, ACRYLICS)

_____

_____

_____

_____

Are you under a physician's care? O **Yes** O **No**

What for:

Family Physician: **Phone:**

Have you been hospitalized or had any in-patient or out-patient surgeries in the past five years?

o No o Yes, explain _____

LIST ALL MEDICATIONS, PILLS, VITAMINS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Patient Signature (or Parent/Guardian): **Date:**

Doctor Signature: **Date:**

:

Date:	Changes:	Patient Initial:	Doctors Signature:
Date:	Changes:	Patient Initial:	Doctors Signature:
Date:	Changes:	Patient Initial:	Doctors Signature:

NOTICE OF PRIVACY NOTICE – WRITTEN PERMISSION

There's been a development in the health industry that requires us to get your written permission in case we ever need to share your treatment information with a specialist, dental lab, or an insurance company. When you sign this form, you give us your approval to share your treatment information and you acknowledge that you are aware of our potential need to do so.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices. I also give my permission should it be necessary to share my treatment information. A copy of this notice and acknowledgement will be kept in my Patient file.

You may refuse to sign this acknowledgement. However, without your signature, we cannot file your insurance or treat you today.

Please Print your Name:

Patient Signature:
Date:

For Office Use Only (Patients should not write below this line):

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgment could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please specify):

WE RESERVE THE RIGHT TO REFUSE FUTURE APPOINTMENTS FOR NO-SHOWS AND LATE CANCELLATIONS

OUR FINANCIAL INFORMATION

- Payment is due at the time service is provided. Our office accepts **cash, personal checks, MasterCard, Visa, American Express and Discover**. Outside financing is available upon request and approval.
- **Please check if you would like more information about financing options.** ☐
- **Please Note:** Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal services, you will be responsible for any collection and/or legal charges incurred up to 35%.

NO SHOW FEE or Less than 48 hours cancellation Fee will be charged of $75.00

In today's insurance market, many patients have lost the ability to choose their own dentist! While Dr.Tarantola is not on any specific provider lists, he serves many patients as an "out-of-network" dentist.

Being in-network severely limits the ability to tend to the extra details necessary to provide dentistry in a holistic way.

We will file your claim for you and help you receive the entire benefit due to you under the terms of your plan.. Since patients value Dr. Tarantola's approach to dentistry, many have opted out of their networks to come see Dr. Tarantola. We will gladly assist you in determining your coverage.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MYSELF, THE PATIENT.

Consent: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. All procedures, tests and treatments will be fully explained to your satisfaction before anything is done.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

PATIENT SIGNATURE (Parent of Child):_____ DATE:_____