2820 Selwyn Avenue Suite 280
Charlotte North Carolina 28209

980.219.7078

tranquilfamilydentistry@gmail.com

TranquilFamilyDentistry.com

Facebook.com/TranquilFamilyDentistry

Welcome to Tranquil Family Dentistry!

Thank you for choosing Tranquil Family Dentistry for your future dental care. We understand that selecting the right dentist is an important decision affecting many aspects of your life—not just your teeth. How your dentist treats you—and your oral health—affects your smile, how you look and feel, what others think of you, aspects of your overall health, your schedule, and your well being. We look forward to meeting you on _____ and earning the valuable trust you've placed in us.

At your first appointment, Dr. Grace Savage, Dr. Nancy Acampado and our staff will set the stage for a caring relationship with you based on a thorough understanding of your needs by analyzing the structural and functional factors of your jaw joints, muscles, and teeth. This personalized information about your dental health will be referenced in a comprehensive approach to your care. Unlike most dentists, Dr. Acampado and Dr. Savage will approach your oral health by practicing Complete Dentistry. By emphasizing prevention and early detection and treatment of disease, tooth wear, and functional problems, Drs. Acampado and Savage will be able to identify the signs of dental problems before any symptoms and damage appear. This will save you from experiencing pain, spending money toward costly and repeated treatments.

From your very first appointment, you'll notice an immediate difference in the dedicated care you receive. Because of their dedication to advanced continuing education, Drs. Acampado and Savage are two of only 10% of dentists in the country who practice the concept of Complete Dentistry. Through proper diagnosis and treatment planning, you'll be able to receive treatments in a more conservative manner, which will allow you to keep as much of your natural tooth structure as possible and help you maintain a healthy and beautiful smile for your lifetime.

Again, thank you for choosing Dr. Grace Savage, Dr. Nancy Acampado and our practice for your dental care. We look forward to serving you with uncompromising integrity.

Sincerely,

Nancy M. Acampado, DDS Grace H. Savage, DDS

Tranquil
family dentistry

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Our office is conveniently located at Tranquil Court in Myers Park at the intersection of Selwyn Avenue and Colony Road. We are only 5 miles from Uptown Charlotte, and 2 miles from South Park Mall.

Parking is available in the rear parking deck as well as an additional covered parking deck 1 floor below. The office, on the 2nd floor, has convenient elevator access. When you exit the elevator, exit to the second floor outdoor walkway and turn left.
We ask that you come 10 minutes prior to your appointment time, so that we may complete your patient registration, and address any questions prior to your visit. If you hqve dental insurance, please bring your insurance card with you.

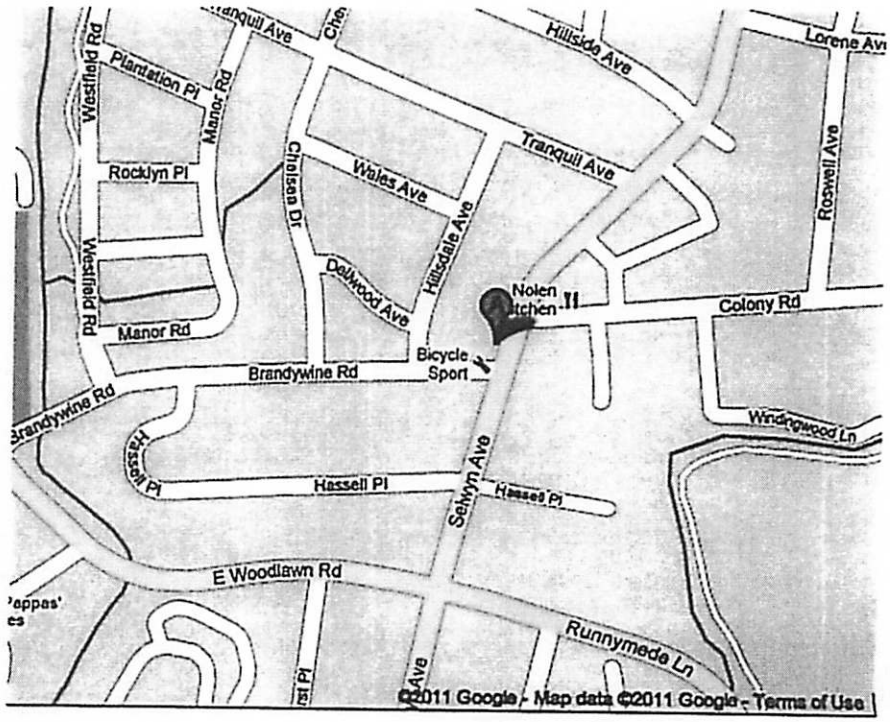
Your completion of the two enclosed forms will make your initial visit go a little more smoothly.

1. Confidential Information Questionnaire/ Financial Policy (double sided)
2. Dental/Medical History (double sided)

The first form will allow us to establish accurate information for you dental accounting records. The second form is very important as it will allow us to get to know your dental and medical history, and help us evaluate any current medical concerns that may contribute to dental disease, and to explore questions you may have regarding your oral health. Our Notice of Privacy Practices will provided to you when you come for your appointment.

We look forward to seeing you on _____

If you are unable to keep your appointment, we ask that you please contact our office at least 24 hours in advance.



CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME	LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PATIENT'S ADDRESS	STREET	APT#	CITY	STATE	ZIP	EMAIL	HOME PHONE

MARITAL STATUS ❑ M ❑ S ❑ D ❑ W ❑ UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS	STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK ❑ YES ❑ NO

SPOUSE'S NAME	LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS	STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK ❑ YES ❑ NO

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP	HOME #	WORK #	CELL #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

SECONDARY COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date _____

PATIENT NAME:_____ PIN: _____

I hereby authorize my dentist Drs N. Acampado/G. Savage and whomever he/she may designate as his/her assistants and/or hygienists, to perform upon me those dental procedures which we have discussed, and I have accepted in the treatment plan. If any unforeseen condition arises in the course of these designated procedures calling, in their judgement, for procedures in addition to or different from those now contemplated, I further request and authorize whatever he/she deems advisable.

I consent to the treatment plan I have accepted after having been advised of alternate plans of treatment available.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post-operative pain and throbbing, swelling and reinfection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings.

The most common of these complications in oral surgery include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, and loss or loosening of dental restorations. Other less common complications include, but are not limited to: infection, loss or injury to adjacent teeth and soft tissues, jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, nerve disturbances (e.g. numbness in mouth and lip tissues), and small root fragments remaining in the jaw which might require extensive surgery for removal. These complications may be temporary or permanent.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reactions), cardiac arrest, thrombophlebitis, (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

A more complete explanation of all complications is available to me upon my request from the Doctor.

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

DATE	PATIENT/PARENT/GUARDIAN SIGNATURE	DOCTOR/STAFF
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____
__/__/__	_____	_____

Financial and Cancellation Policy

A. _____ **I would like to have Tranquil Family Dentistry file my insurance on my behalf.** I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover at time of service. I hereby authorize payment directly to Tranquil Family Dentistry otherwise payable to me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance.

I will be responsible for any remaining balance beyond of the reimbursement amount provided by my insurance coverage. I understand that I will receive a statement if there is a balance left from any treatment, and that I have the opportunity to pay the balance at that time.

Signature_____ Date_____

Print Name_____

B. _____ **I do not choose to leave a card on file. I agree to pay the full fee for all services received on the day of my visit.** I understand that Tranquil Family Dentistry will still file my insurance for me, and if available, on my behalf. **I will then be directly reimbursed by my insurance company** within a few weeks following the filed claim. I further understand that I will be responsible to pay in full for any routine visits (including exams, x-rays, and routine cleanings) even if they will be reimbursed to me in full.

Signature_____ Date_____

Print Name_____

C. _____ Our office understands that sometimes unforeseen circumstances may prevent you from keeping your scheduled appointment. However, **we do request that you notify us at least one full business day prior to your scheduled appointment time, if you are unable to keep your appointment.** Our office is open Monday through Thursday. *We are reserving this time for you, so please have the courtesy to notify us when these changes occur in your schedule.*

If you do not show for your scheduled appointment or if we do not receive notice within one full business day, we reserve the right to charge a broken appointment fee of $50. For any appointment for treatment procedures with the dentist, fee will be determined according to the treatment scheduled. This fee must be paid prior to any future visits.

Signature_____ Date_____

Privacy Policy

D. Privacy Policy: I have received the Notice of Privacy Practices provided by this office.

Signature _____ Date _____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____ How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning sensation in your mouth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26. Are your teeth developing spaces or becoming more loose? _____	☐	☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____	☐	☐
32. Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
34. Have you ever whitened (bleached) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date_____
Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver,_____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement)_____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder_____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma_____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency_____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c=_____)_____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐

	YES	NO
27. arthritis _____	☐	☐
28. autoimmune disease _____	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth_____	☐	☐
36. hives, skin rash, hay fever_____	☐	☐
37. STI / STD / HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV / AIDS _____	☐	☐
40. tumor, abnormal growth_____	☐	☐
41. radiation therapy_____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties_____	☐	☐
44. psychiatric treatment_____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol / recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours		
(i.e. fever, chills, new cough, or diarrhea)_____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements_____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches_____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed_____	☐	☐
56. FEMALE - taking birth control pills _____	☐	☐
57. FEMALE - pregnant _____	☐	☐
58. MALE - prostate disorders_____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)** 

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment, but in refusing, **we will not be allowed to process your insurance claims.**

Date _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **Tranquil Family Dentistry**.

A copy of this signed, dated Acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____

Please ***print*** your name | Please ***sign*** your name

_____ _____

Legal Representative | Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION (This includes step parents, grandparents, and any care takers who can have access to the patient's records):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ U.S. Mail/Postcard

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Text Message to my Cell Phone
- ☐ Email Message
- ☐ U.S. Mail/Postcard
- ☐ Any of the above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, OR NEW DENTAL INFO** VIA:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ U.S. Mail/Postcard
- ☐ Any of the above

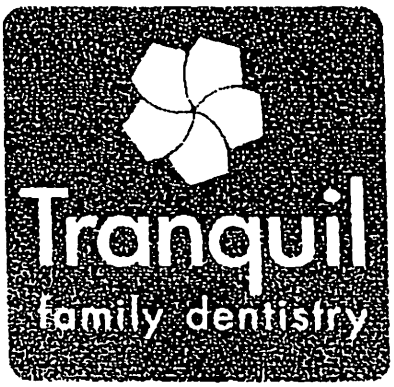
Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement, but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because
- ☐ Other (please describe) _____

_____

Signature of Privacy Officer



Authorization For Release of Dental Record

NAME OF PATIENT_____ DOB_____

ADDRESS OF PATIENT_____

_____

_____

I HEREBY AUTHORIZE _____ TO RELEASE MY MEDICAL AND DENTAL INFORMATION TO:

Tranquil Family Dentistry
2820 Selwyn Ave Suite #280
Charlotte, NC 28209
980-219-7078
tranquilfamilydentistry@gmail.com

The Information To Be Disclosed Is:

_____ Medical/dental History

_____ Treatment/progress Notes

_____ Dental X-rays

_____ Other

_____

Signature Of Patient_____ Date_____

(Parent or Guardian If patient is a minor)