



Dental Arts  
of Florida

# CONFIDENTIAL

Dr. Fred Tepedino & Associates

Welcome to our practice!

Thank you for selecting our practice, we are glad that you have chosen to become a part of a great dental experience. Please fill out the following forms completely in ink. If you have any questions or concerns, please do not hesitate to ask our front office staff for assistance. We will be happy to help!

### Patient Registration Information

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Gender:  Male  Female      Last      First      Initial      Marital Status:  Married  Single  Child  Other

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

Drivers License Number: \_\_\_\_\_ Issuing State: \_\_\_\_\_

Home Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_      Work Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_      Cell Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

Preferred Contact Method:  Home  Cell  Work  E-Mail  Text Message

Home Address: \_\_\_\_\_ Billing Address:  Same as Home  
\_\_\_\_\_  
\_\_\_\_\_

**Work Information:**  
Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_

**Spouse/Parent Information:**  
Name: \_\_\_\_\_  
Gender:  Male  Female  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Who is Responsible For this Account:**  
Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_

**Insurance Information:**  
Do you have Dental Insurance  Yes  NO  
Dental Insurance Company Name: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Name of Subscriber: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_  
Subscriber Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Group Number: \_\_\_\_\_  
Subscriber Employer: \_\_\_\_\_



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### Additional Dental Insurance:

Do you have Any Additional Dental Insurance?  Yes  NO

Dental Insurance Company Name: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Subscriber Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

### Emergency Contact Information:

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Number: Home: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Authorization, Release, and Agreement to Pay for Services Rendered:

I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners that I may be referred to.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependent(s).

I authorized Frederico Tepedino D.M.D Pa and associates to notify me of upcoming appointments via electronic communications.

X \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature of Patient or Parent/ Guardian if Minor

### Financial Arrangements:

For your convenience, we offer the following Methods of payment:

Cash,  Personal Check  Credit Card (Visa/MC/Amex/ Discover)  Care Credit  HAS and Flex Spending Cards.

*Ask us about financing option's available to you!*

How did you Hear About our office:  PPO Insurance Provider List  Real Yellow Pages Phone Book

YP.Com  Internet  Direct Mail  Referring Patient: \_\_\_\_\_  Referring Dentist: \_\_\_\_\_

### Late Charges:

If I do not pay the entire new balance with in 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and additional attorney fees incurred in attempting to collect on this amount or any further outstanding account balances.

## Patient Medical History

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	Yes	No		Yes	No
Are you in good Health	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever required a blood Transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Have there been any changes in your general Health with in the last year	<input type="checkbox"/>	<input type="checkbox"/>	Have you had Recent Weight Loss?-	<input type="checkbox"/>	<input type="checkbox"/>
Date of your last Physical Exam: _____			Have you ever taken Fen-Phen/ Redux-	<input type="checkbox"/>	<input type="checkbox"/>
Physicians Name: _____			Do you use Tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Physicians Phone Number: _____			Do you or have you used controlled Substances?	<input type="checkbox"/>	<input type="checkbox"/>
Are you under the care of a Physician?	<input type="checkbox"/>	<input type="checkbox"/>	Are you wearing contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized for any surgical Operation or serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a disease, condition, or problem not Listed You think I should know about?	<input type="checkbox"/>	<input type="checkbox"/>
Please Explain: _____			Have you had any abnormal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any Medicine(s) including any Non prescription Medications(s)	<input type="checkbox"/>	<input type="checkbox"/>	Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>
Please List: _____			<b>Woman Only:</b>		
			Are you Pregnant or think you may be or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

**Are you allergic to or have you had reactions to:**

Local Anesthetics like novocaine	<input type="checkbox"/>	<input type="checkbox"/>	barbiturates, sedatives, or sleeping pills, iodine	<input type="checkbox"/>	<input type="checkbox"/>
penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Any metals (e.g., nickel, mercury, etc)	<input type="checkbox"/>	<input type="checkbox"/>
sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Latex/rubber	<input type="checkbox"/>	<input type="checkbox"/>

**Do you have or have you ever had any of the following:**

Rheumatic heart disease or rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
heart defect <input type="checkbox"/> or Heart Murmur <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis Or Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble <input type="checkbox"/> Heart Attack <input type="checkbox"/> Angina <input type="checkbox"/> Heart Surgery <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>
pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Feet, Hands, Ankles	<input type="checkbox"/>	<input type="checkbox"/>	persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis <input type="checkbox"/> Jaundice <input type="checkbox"/> Liver Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy (Cancer, Leukemia)	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lung/ Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy <input type="checkbox"/> Seizures <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Hives or skin rash	<input type="checkbox"/>	<input type="checkbox"/>	nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	tumors	<input type="checkbox"/>	<input type="checkbox"/>
Aids <input type="checkbox"/> HIV Infection <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	mental Health Care	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctors Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Doctors Notes:*

## Patient Dental History

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for this visit: \_\_\_\_\_

Do you want us to limit your treatment to this chief Complaint?  Yes  NO

When was your last dental visit? \_\_\_\_\_ What was done then? \_\_\_\_\_

How often did you visit the dentist before then? \_\_\_\_\_

Previous Dentist (Name & Location): \_\_\_\_\_

Have you had a complete series of dental films (x-rays) taken?  Yes  NO  Not Sure

If so when and Where? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you Floss? \_\_\_\_\_

Is your Drinking Water Fluoridated  Yes  NO  Not Sure

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing? -----	<input type="checkbox"/>	<input type="checkbox"/>	Do you Bite our lips or cheeks often? -----	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids or foods? -----	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any loosening of your teeth? -----	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain in any of your teeth? -----	<input type="checkbox"/>	<input type="checkbox"/>	Does food tend to become caught between your teeth? -----	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth? -----	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had Periodontal treatment (gums)? ---	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any Head/Neck/Jaw injuries? -----	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever worn a bite plate or other appliance?--	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any of the following problems in your jaw?			Have you ever had any difficult extractions in the past? -----	<input type="checkbox"/>	<input type="checkbox"/>
Clicking-----	<input type="checkbox"/>	<input type="checkbox"/>			
Pain (Joint/ Ear/ Side of Face) -----	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received oral hygiene instructions regarding the care of your teeth and gums? -----	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing-----	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in Chewing-----	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any prolonged Bleeding following extractions? -----	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent headaches? -----	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear Dentures or partials		
Do you clench or grind your teeth? -----	<input type="checkbox"/>	<input type="checkbox"/>	If yes date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>

If you could change anything about your smile, what would you change? \_\_\_\_\_

### Authorization & Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child 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 dentist or dental group 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 payment of all services rendered on my behalf or my dependents.

*Signature of Patient or Parent/Guardian if Minor*

*Date*

Effective: 05/1/2013



**Dental Arts**  
of Florida

7645 Gate Parkway, Suite #103  
Jacksonville, FL 32256  
904-998-9820

**MISSED/CANCELED APPOINTMENT POLICY**

To Our Valued Patients:

If you find you are unable to keep a scheduled appointment, we would appreciate it if you could kindly give us notice. While we understand the fact that sometimes unavoidable situations may occasionally arise, we reserve the right to assess the following missed appointment charges:

- 1 Hour Appointment: \$25 (without 24 Hour Notice)
- 2 Hour Appointment: \$50 (without 48 Hour Notice)
- 2 ½ Hour Appointment: \$100 (without 72 Hour Notice)
- **All Saturday and Sunday Appointments:** \$50 (without 72 Hour Notice)

Thank you for your cooperation and understanding,

Dental Arts of Florida,  
Fred Tepedino, D.M.D., P.A

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Patient Signature

Date

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Parent/Guardian Signature

Date

**TREATMENT PLAN POLICY**

Treatment plans are an **estimate** valid for **90** days from the date entered. If during the course of treatment it becomes imperative to alter plans, you will be informed of any necessary changes. The estimate of benefits is not a guarantee of payment by insurance. Benefits are affected by eligibility at the time of service, policy provisions and limitations, and benefits that may have been paid to another office. The estimate of benefits is based on information that your insurance carrier provided to our office. We do all we can to correctly estimate your out-of-pocket expenses, but please be aware that you as the policy holder are responsible to know the coverage provided by your policy. You are ultimately responsible for all charges.

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Signature

Date

**\*\* All Requests for Duplication of X-rays will incur a charge of \$25.00 they are part of our patient records. All X-rays will be provided to any referred doctor at no charge to the patient. Payment and release will be due at time of request of duplication.**





Dental Arts  
of Florida

Fred Tepedino, D.M.D, P.A. & Associates

COSMETIC AND GENERAL DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT  
OF JOINT NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Joint Notice of Privacy Practices of Dental Arts of Florida, P.A. and Fred Tepedino, D.M.D, with the option to retain a copy for my records.

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Please Print Name

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Signature

---

Date

\*\*You may refuse to sign this acknowledgement.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Joint Notice of Privacy Practices, but acknowledgement could not be obtained because:

- D Individual refused to sign.
- D Communication barriers prohibited obtaining the acknowledgement.
- D An emergency situation prevented us from obtaining the acknowledgement.
- D Other (please Specify)

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\*\*\*COPY OF POLICY AVAILABLE UPON REQUEST\*\*\*