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:** _____
Last First Initial

Gender: ❑ Male ❑Female **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: _____

Who is Responsible For this Account:

Name: _____

Relationship to Patient: _____

Spouse/Parent Information:

Name: _____
Gender: ❑ Male ❑ Female
Date of Birth: ____/____/____
Social Security Number: ____/____/____

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: _____

Dental Arts
of Florida

CONFIDENTIAL

Dr. Fred Tepedino & Associates

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:_____ ❑ ReferringDentist:_____

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	❑	❑	Have you ever required a blood Transfusion?	❑	❑
Have there been any changes in your general Health with in the last year	❑	❑	Have you had Recent Weight Loss?-	❑	❑
Date of your last Physical Exam:			Have you ever taken Fen-Phen/ Redux-	❑	❑
Physicians Name:			Do you use Tobacco?	❑	❑
Physicians Phone Number:_____-_____-_____			Do you or have you used controlled Substances?	❑	❑
Are you under the care of a Physician?	❑	❑	Are you wearing contact lenses	❑	❑
Have you ever been hospitalized for any surgical Operation or serious illness?	❑	❑	Do you have a disease, condition, or problem not Listed You think I should know about?	❑	❑
Please Explain:			Have you had any abnormal bleeding?	❑	❑
Are you taking any Medicine(s) including any Non prescription Medications(s)	❑	❑	Do you bruise easily?	❑	❑
Please List:			**Woman Only:** Are you Pregnant or think you may be or think you may be pregnant?	❑	❑
			Are you Nursing?	❑	❑
			Are you taking birth control pills?	❑	❑

Are you allergic to or have you had reactions to:

Local Anesthetics like novocaine	❑	❑	barbiturates, sedatives, or sleeping pills, iodine	❑	❑
penicillin or other antibiotics	❑	❑	Any metals (e.g., nickel, mercury, etc)	❑	❑
sulfa drugs	❑	❑	Latex/rubber	❑	❑

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

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

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? ----------	❑	❑	Do you Bite our lips or cheeks often? ----------	❑	❑
Are your teeth sensitive to hot or cold liquids or foods? ----------	❑	❑	Have you noticed any loosening of your teeth? --------	❑	❑
Do you feel pain in any of your teeth? ----------	❑	❑	Does food tend to become caught between your teeth? ----------	❑	❑
Do you have any sores or lumps in or near your mouth? --------	❑	❑	Have you ever had Periodontal treatment (gums)? ---	❑	❑
Have you had any Head/Neck/Jaw injuries? ----------	❑	❑	Have you ever worn a bite plate or other appliance?--	❑	❑
Have you ever experienced any of the following problems in you jaw?			Have you ever had any difficult extractions in the past? ----------	❑	❑
Clicking----------	❑	❑			
Pain (Joint/ Ear/ Side of Face) ----------	❑	❑			
Difficulty in opening or closing----------	❑	❑	Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ----------	❑	❑
Difficulty in Chewing----------	❑	❑			
Do you have frequent headaches? ----------	❑	❑	Have you ever had any prolonged Bleeding following extractions? ----------	❑	❑
Do you clench or grind your teeth? ----------	❑	❑	Do you wear Dentures or partials If yes date of placement_____	❑	❑

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

Patient Signature Date

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.

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.

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless/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. It is very important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

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.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking, antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. 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.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure, or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations, or gums.
5. Possible deterioration of your condition, which may result in tooth loss.
6. The need for replacement of restorations, implants, or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip, bone fragment, or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication.
13. Need for follow-up treatment, including surgery.

This 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 accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

I hereby give Frederico Tepedino D.M.D PA and Associates and all employees and/or agents of Frederico Tepedino D.M.D PA and Associates the right and permission to use and/or publish photographs of me for art, promotional and educational purposes ***(including but not limited to, advertising, publicity, commercial or display of use).*** ☐ **Decline**

Patient Signature	Date	Witness Signature	Date
Print Patient Name		Parent/Legal Guardian	Date

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.

Please Print Name

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)

COPY OF POLICY AVAILABLE UPON REQUEST