Dental Arts of Florida, P.A.
CONFIDENTIAL
Dr. Fred Tepedino & Associates

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out the following forms completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help!

Patient Registration Information

Patient Information:

Name:_____ **Preferred name**:_____
Last First Initial

Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Date of Birth:____/____/____ **Social Security Number**:____-____-____

Driver's License Number:_____**Expiration date**:_____

Home Phone:_____**Cell Phone**:_____

Email:_____

Preferred contact method: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Text message

Who is responsible for this account?_____ Relationship:_____

Home Address:

_____

_____

Billing Address: ☐ Same

_____

_____

Work Information:

Employer:_____
Occupation:_____
Work Phone:_____
Other family members in our practice:
_____
_____

Spouse / Parent Information:

Name:_____
Gender: ☐ Male ☐ Female
Date of Birth:____/____/____
Social Security Numbers:____-____-____
Employer:_____
Occupation:_____

Insurance Information:

Do you have dental insurance? ☐ Yes ☐ No

Dental Insurance Company:_____ Ins. Phone:_____

Name of Policy Holder:_____ ID #:_____

Group#:_____ Employer:_____

Policy Holder DOB:____/____/____

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Additional Dental Insurance Information:

Do you have any Additional Dental Insurance: ☐ Yes ☐ No

Dental Insurance Company:_____ Ins. Phone:_____

Name of Policy Holder:_____ ID #:_____

Group#:_____ Employer:_____

Policy Holder DOB:_____/_____/_____

Emergency Contact Information:

Full name:_____Relationship:_____

Contact Number: Home:_____ Cell:_____

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 a third party payer 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 dental group) insurance benefits otherwise payable to me.

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

I authorize Frederico Tepedino DMD P.A. and Associates to notify me of upcoming appointments via electronic communication.

I understand that treatment rendered cannot be canceled and services are not refundable once complete

X_____ Date:_____

Signature of Patient / Guardian of Minor

Financial Arrangements:

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

☐ Cash ☐ Personal Checks ☐ Credit Cards (visa, amex, discover) ☐ Care Credit ☐ HAS and Flex Spending Cards

Ask us about financing options 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 Doctor:_____

Late charges: If you do not pay the entire new balance within 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 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:_____ DOB:_____/_____/_____

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!

Are you in good health? Yes ☐ No ☐
Have there been any changes in your general health within the last year? Yes ☐ No ☐
Date of your last Physical Exam:
_____
Physician's name:
_____
Physicians phone number:_____
Are you under the care of a Physician? Yes ☐ No ☐
Have you ever been hospitalized for any surgical operation or serious illness? Yes ☐ No ☐
Please explain:_____
_____

Have you ever required a Blood Transfusion? Yes ☐ No ☐
Have you had recent Weight Loss? Yes ☐ No ☐
Have you ever taken Fen-Phen / Redux? Yes ☐ No ☐
Do you use tobacco? Yes ☐ No ☐
Do you or have you used controlled substances? Yes ☐ No ☐
Are you wearing contact lenses? Yes ☐ No ☐
Do you have a disease, condition or problem not listed, you think we should know about? Yes ☐ No ☐
Have you had any abnormal bleeding? Yes ☐ No ☐
Do you bruise easily? Yes ☐ No ☐

Pharmacy:_____
Pharmacy Phone#:_____

Are you taking any Medicine(s) including any Non-Prescribed Medication(s)? Yes ☐ No ☐
Please List:
_____
_____
_____

Women only:

Are you Pregnant or think you may be Pregnant? Yes ☐ No ☐
Are you nursing? Yes ☐ No ☐
Are you taking birth control? Yes ☐ No ☐

Are you allergic to or have you had reactions to:

Local Anesthetic (like novocaine) Yes ☐ No ☐
Penicillin or other antibiotics Yes ☐ No ☐
Sulfa Drugs Yes ☐ No ☐
Barbiturates, Sedatives, or Sleeping Pills, Iodine Yes ☐ No ☐
Any Metals (e.g., Nickel, Mercury, etc.) Yes ☐ No ☐
Latex / Rubber Yes ☐ No ☐

	Yes/No			Yes/No	
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 Disorder	☐	☐
Shortness of Breath	☐	☐	Joint Replacement or Implant(s)	☐	☐
Pacemaker	☐	☐	Stomach Ulcers	☐	☐
Back Problems	☐	☐	Kidney Trouble	☐	☐
High Blood Pressure Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Swelling of Feet, Hands, Ankle	☐	☐	Persistent Cough	☐	☐
Hepatitis ☐ Jaundice ☐ Liver Disease ☐	☐	☐	Cough that produces blood	☐	☐
Stroke	☐	☐	Chemotherapy (Cancer, Leukemia)	☐	☐
Sinus Trouble	☐	☐	Sexually Transmitted Disease	☐	☐
Lung or Breathing Problems	☐	☐	Epilepsy ☐ Seizures ☐	☐	☐
Asthma or Hay Fever	☐	☐	Anemia	☐	☐
Hypoglycemia	☐	☐	Glaucoma	☐	☐
Hives or Skin Rashes	☐	☐	Nervousness	☐	☐
Fainting or Dizzy Spells	☐	☐	Tonsillitis	☐	☐
Diabetes	☐	☐	Tumors	☐	☐
Aids ☐ HIV ☐ Infection ☐	☐	☐	Mental Health Care	☐	☐
Blood Thinners	☐	☐	Blood Disease	☐	☐

Patient Signature:_____ **Date:**_____ **Dr. Signature:**_____

Patient Dental History

Patient name:_____

Reason for visit:_____

Do you want us to limit your treatment to this chief complaint? ☐ Yes ☐ No

When was your last dental visit?_____ What was done?_____

How often did you visit the dentist?_____

Previous Dentist (name & location):_____

_____

Have you had a complete series of dental films (x-rays) taken? ☐ Yes ☐ No ☐ Not sure

If yes, when and where were they taken?_____

How often do you brush your teeth?_____How often do you floss?_____

Is your drinking water Fluoridated? ☐ Yes ☐ No ☐ Not sure

Do your gums bleed while brushing or flossing? Yes ☐ No ☐	Do you bite your lips or cheeks often? Yes ☐ No ☐
Are your teeth sensitive to hot or cold liquids or foods? Yes ☐ No ☐	Have you noticed any loosening of your teeth? Yes ☐ No ☐
Do you feel pain in any of your teeth? Yes ☐ No ☐	Does food tend to become caught between your teeth? Yes ☐ No ☐
Do you have any sores or lumps in or near your mouth? Yes ☐ No ☐	Have you ever had Periodontal treatment (gums)? Yes ☐ No ☐
Have you had any Head/Neck/Jaw injuries? Yes ☐ No ☐	Have you ever worn a bite plate or other appliance? Yes ☐ No ☐
Have you ever experienced any of the following problems in your jaw?	Have you ever had any difficult extractions in the past? Yes ☐ No ☐
Clicking..... ☐	Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes ☐ No ☐
Pain (joint/ear/side of face)..... ☐	Do you wear dentures or a partial? Yes ☐ No ☐
Difficulty in opening or closing..... ☐	If yes, date of placement?_____
Difficulty in chewing..... ☐	
Do you have frequent headaches? Yes ☐ No ☐	
Do you clench or grind your teeth? Yes ☐ No ☐	

If you could change anything about your smile, what would it be?_____

_____

_____

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 during the period of such dental care to a third party payer and/or other health practitioners that I may be referred to.

Patient Signature:_____ **Date:**_____

INFORMED CONSENT FORM 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 treatment, 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 medications, 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 chance of poor outcome.

Certain heart conditions may cause a risk of serious or fatal complications. If you (or 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. I addition to complying with 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 medications, you must consider the fact that antibiotics might make the oral birth control less effective. Please consult with your physician before relying on the 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 complicated 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 lips, face, chin, gums, and tongue, along with possible loss of tissue.
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 infection or the need for future 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 you dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

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

Dental Arts
of Florida
Dr. Fred Tepedino & Associates
7645 Gate Parkway Suite 103
Jacksonville, FL32256
(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 miss appointment charges:

- **1 Hour appointment: $25 (without 48 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, DMD, 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 provides 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 that coverage provided by your policy. You are ultimately responsible for all charges.**

Patient Signature Date

**All requests for Duplication Xrays will incur a charge of $25.00, they are a part of our patient records. All xrays will be provided to any referred doctor at no charge to the patient. Payment and signed release will be due at the time of request of duplication.

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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, DMD, with the option to retain a copy for my records.

Please print name

Signature Date

**I authorize these additional persons to have access to my personal dental and/or medical information.

Name:_____ Relationship: _____

Name:_____ Relationship: _____

**You may refuse to sign this acknowledgement.

For Office Use Only

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

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

COPY OF POLICY AVAILABLE UPON REQUEST