

Hello!

One of the most difficult decisions you will have to make is finding a dentist. We would like to help you make that decision in keeping with your expectations of high quality dental care.

We are delighted to welcome you to our practice and are pleased to serve your dental needs. We are serious about providing superior dental care, and proud of our dedication to our patients. Our goal is to help you feel and look your very best!

Dentistry has seen dramatic changes over the years. New materials and techniques have given us the means to perform amazing smile transformations. To restore your teeth to their optimal condition, we can place the highest quality crowns, partials, and dentures. Cosmetically, we can transform your smile using the latest techniques with veneers, whitening, amalgam removal and an array of other procedures in order to help you look good and feel good!

For the convenience of all our patients, we strive to see everyone in a timely fashion. To facilitate being seen just as soon as possible at the time of your appointment, we would appreciate it if you would complete the enclosed Patient Information and Consent Forms before your arrival. **Please bring the completed forms with you to your appointment.** Since the paperwork does require some time to complete, any delay may result in us having to reschedule your appointment.

If you are unable to make the appointment you have scheduled with us, please notify us **at least 48 hours** in advance. We would be glad to reschedule the appointment at a more convenient time. In the meantime, we look forward to meeting you and serving your needs.

If there is any additional information you require, please call and we will be happy to assist you. Thanks again for choosing our dental practice.

Warmest Regards,

Dr. Petrilli and Team

Scheduling Appointments

New patients are always welcome! We currently accept new patients age 18 and up. We also do our best to accommodate emergency appointments whenever possible. These appointments may be made as availability allows only.

Our regular office hours are Monday through Thursday from 8 am to 5 pm. We are closed from 12 pm to 1 pm daily for lunch. Patients are seen by appointment only.

Dr. Petrilli’s office is closed on Fridays, weekends, major holidays, and when we are away at continuing education programs. The office answering system is always available to take messages and to help you access care in the event of an emergency. Our office telephone number is **(407) 884-1846**.

Initials _____

Appointment Cancellation Policy

Appointments reserve the doctor’s time especially for you. As a courtesy, you will receive a confirmation call on the **business day** we are open prior to your appointment. All attempts will be made to reach you and speak with you directly. Please make sure that we have as many numbers as possible where we may reach you in order to assist us with this confirmation process. It is your responsibility to ensure we have a working phone number on file.

If you are unable to keep an appointment, please give us one business day of notice to prevent a charge **unless a longer period has been otherwise specified for your particular appointment**. This courtesy on your part will make it possible to give your appointment time to another patient in need. Additional notice and /or a deposit may be required for some longer appointments.

Please understand that in an effort to control costs, **patients will be billed for late cancellations or no-shows regardless of reason**. *Please schedule only definitive appointments.* Rescheduling will not be possible until outstanding balances are paid in full.

Despite careful scheduling, emergencies can cause delays. We try our very best to stay on time. If your appointment time is affected due to an unforeseen emergency, we will do everything we can to notify you in advance. We know that your time is valuable. You will receive the same high quality dental care during your appointment.

Initials _____

Annual exams and x-rays

Because we are dedicated to helping you maintain your dental health, bite wing x-rays and an exam are required a minimum of once per consecutive 12 month period.

Initials _____

X-Ray / Record Duplication Services

We are required to maintain legal custodianship of original x-rays and written records in our office. We will be happy to provide you with duplicate copies.

We require 24 hour notice for duplication of x-rays and records. Requests made prior to 12 pm will be ready for pick up by 8:00 am the following business day. Requests made after 12 pm will be ready for pick up by 1:00 pm the following business day. There may be a \$10.00 per person charge for the duplication of x-rays when transferring out of office. There is no charge for the duplication of written records only.

Please be advised that certain specialists may require a panoramic x-ray. We do not have the required equipment to take panoramic x-rays and therefore, these will need to be taken at the specialist’s office.

Initials _____

Financing Options

We base our fees on our quality, expertise, time, and service. We clearly list and explain all our fees during your treatment consultation visit. We ask you to pay at each visit, unless other arrangements have been made in advance of your appointment. To make payment more convenient for you, we accept cash, personal checks with valid ID, Visa, MasterCard, American Express and CareCredit Healthcare Financing.

Initials _____

Dental Insurance Policies

Many of our patients have dental insurance. Your dental insurance policy is an agreement between you and your insurance company. It is your responsibility to know if your plan has any waiting periods, missing tooth clauses, or any other specific clauses that would prevent them from paying for a procedure.

We will be happy to assist you in preparing and sending in the necessary forms required to process your claim. We do NOT file with secondary insurances. Please remember that no insurance company attempts to cover all dental costs. We will do our best to **estimate** what your insurance will pay towards your treatment. We will be happy to supply any information your dental insurance carrier needs and help you receive the maximum benefits.

Please remember...Payment to our office remains your responsibility, regardless of how much your insurance does or does not pay.

I understand and accept these office policies:

Signature Date

Your Name: _____

Because of our emphasis on personalized dental care, our practice is unlike other dental offices. Your first visit is extremely important in determining your present and future dental needs. The issues on this form will be discussed at your first visit.

- Are you having any areas of concern? _____
- How would you describe the present state of the health of your mouth? _____

- What do you already know about our office & what are your expectations? _____

- How healthy do you want us to get your mouth?
 - Don't really care
 - Average
 - The best it can be
- Should you need treatment, at what point should we address it?
 - When a tooth hurts or breaks
 - When something is worsening
 - When something isn't ideal
- What quality of dentistry do you want us to recommend?
 - Just patch it up
 - Average
 - Ideal/The best
- We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you?
 - General dentistry
 - Cosmetic dentistry
 - Functional dentistry
- How do you feel about the appearance of your face & smile? _____

- What would it take for you to trust us to be your dentist? _____

- Tell us about your good dental experiences _____

- And the bad ones? _____
- Has fear ever been an issue for you in a dental office? _____
- What caused you to leave your last dental office? _____

- Has time ever been a factor in getting your dental work done? _____
- Has the cost of dental treatment been a concern for you? _____
What can we do to help you with this? _____

Is there any additional information you would like us to know? _____

DENTAL HISTORY

Patient Name _____

Date _____

Richard Petrilli DMD PA
Comprehensive Adult Dentistry
1585 North Rock Springs Road
Apopka FL 32712
407-884-1846

Providing Extraordinary Care For Extraordinary Patients

Welcome! So that we may provide you with extraordinary care, please complete the following.

What is the reason for your visit today? _____

Date of Last Dental Visit: _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____ City, State _____

How often do you have dental examinations: _____

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

What other dental aids do you use (Interplak, toothpick, etc.)? _____

Do you have any dental problems now? YES NO

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold	Yes	No
Sweets	Yes	No
Biting or Chewing	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, Blisters, or any other oral lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in-between your teeth?	Yes	No
If yes, where? _____		

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Have tired jaws, especially in the morning?	Yes	No

Have you ever had:

Orthodontic treatment or braces?	Yes	No
Oral surgery or your wisdom teeth removed?	Yes	No
Periodontal treatment or gum disease?	Yes	No
Your teeth ground or your bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause? _____		

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Sore muscles (neck, shoulders)	Yes	No

Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No
If yes, please describe _____

Are you satisfied with your teeth's appearance? Yes No
Would you like to keep all of your teeth all of your life? Yes No

If you could rate your smile on a scale from 1 to 10 (with 1 being the worst and 10 being the best), how would you rate your smile? _____

Why? _____

PATIENT INFORMATION

Patient Name _____

Date _____

Richard Petrilli DMD PA
Comprehensive Adult Dentistry
1585 North Rock Springs Road, Apopka, FL 32712
407-901-4747

Providing Extraordinary Care For Extraordinary Patients

Please complete the following confidential information :

Name: _____ Spouse/Partner: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different than above): _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Email address: _____

Date of Birth: ____/____/____ Age: _____ Sex: M F Marital Status: _____

Social Security Number: ____-____-____ Dr. License # _____

Dental Insurance Information (Primary Only)

Insurance Co: _____

Primary Subscriber: _____

Date of Birth: ____/____/____

Social Security#: ____-____-____

Employer: _____

Group #: _____

Additional ID#: _____

Getting To Know You

Your Employer: _____

Occupation: _____

Business Phone: (____) _____ Ext. _____

Business Address: _____

City: _____ State: _____ Zip: _____

Your Former Address: _____

City: _____ State: _____

Emergency Contact: _____

Phone #: _____ Address: _____

City: _____ State: _____

Closest Relative (not living with you): _____

Phone # _____ Address: _____

How Did You Hear About Us?

Is another member of your family or relative a patient at our office?

Name: _____

Relationship: _____

Referred to us by:

___ Yellow Pages ___ Advertisement ___ Website
___ Insurance ___ Friend (please tell us who)

Other: _____

Person Financially Responsible For Account

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: ____/____/____

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the past two years?..... YES NO
3. Have you been under the care of a medical doctor during the past two years?.....YES NO
 - a. Physician's Name: _____ Phone No. _____
 - b. Address: _____
4. Have you taken any medication or drugs during the past two years?..... YES NO
5. Are you now taking any medication, drugs or pills?..... YES NO
 - a. If yes, please list: _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?..... YES NO
 - a. If yes, please list: _____
7. When you walk up stairs or walk, do you ever have to stop due to pain in your chest, shortness of breath, or being very tired? YES NO
8. Do your ankles swell during the day?..... YES NO
9. Do you use more than two pillows to sleep?..... YES NO
10. Have you lost or gained more than 10 pounds in the past year?..... YES NO
11. Do you ever wake up from sleep and feel short of breath?..... YES NO
12. Are you on a special diet?YES NO
13. Has your medical doctor ever said you have a cancer or tumor?YES NO

14. Indicate which of the following you have had or have at present. Circle YES or NO to each item.

Allergies.....	YES	NO	Fainting.....	YES	NO	Multiple Sclerosis.....	YES	NO
Amoxicillin Allergy.....	YES	NO	Glaucoma.....	YES	NO	Muscular Distrophy.....	YES	NO
Angina Pectoris.....	YES	NO	Hay Fever.....	YES	NO	Nervous Disorders.....	YES	NO
Anxiety/OCD/ADD/ADHD.....	YES	NO	Head Injuries.....	YES	NO	Organ Transplant.....	YES	NO
Artificial Joints.....	YES	NO	Heart Attack.....	YES	NO	Pacemaker.....	YES	NO
Asthma.....	YES	NO	Heart Disease.....	YES	NO	Penicillin Allergy	YES	NO
Blind.....	YES	NO	Heart Murmur.....	YES	NO	Psychiatric Treatment.....	YES	NO
Blood Disease.....	YES	NO	Heart Surgery.....	YES	NO	Radiation Treatment.....	YES	NO
Blood Thinner.....	YES	NO	Hepatitis A.....	YES	NO	Respiratory Problems.....	YES	NO
Cancer.....	YES	NO	Hepatitis B.....	YES	NO	Rheumatic Fever.....	YES	NO
Codeine Allergy.....	YES	NO	Hepatitis C.....	YES	NO	Rheumatoid Arthritis.....	YES	NO
Congenital Heart Disease.....	YES	NO	High Blood Press....	YES	NO	Sinus Problems	YES	NO
Cortisone Medication.....	YES	NO	HIV Positive.....	YES	NO	Stomach Problems	YES	NO
Deaf.....	YES	NO	Jaundice	YES	NO	Stroke.....	YES	NO
Diabetes	YES	NO	Kidney Trouble.....	YES	NO	Thyroid Problems	YES	NO
Dizziness.....	YES	NO	Liver Disease.....	YES	NO	Tuberculosis.....	YES	NO
Epilepsy	YES	NO	Medication Allergy...	YES	NO	Tumors.....	YES	NO
Excessive Bleeding.....	YES	NO	Mitral Valve.....	YES	NO			

Do you have any disease, condition, or problem not listed? YES NO If so, please list: _____

FOR WOMEN ONLY: Are you pregnant? YES NO Yes, what month? ____ Are you nursing? YES NO Are you on birth control pills? YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge. **Signature:** _____ **Date:** _____

DOCTOR'S USE ONLY: I have reviewed and discussed the medical history listed above with the patient. _____ Date: _____

I hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics which my dentist deems advisable in the diagnosis and/or treatment of this patient. By signing this medical authorization and consent, I understand that as matter of law it shall be conclusively presumed:

- A. That the action of my dentist in obtaining this consent from me was in accordance with an accepted standard of medical-dental practice among members of the medical-dental profession with similar training and experience in this or similar medical communities; and from information provided me by my dentist, I, under these circumstances, have at least a general understanding of the procedures, the medically accepted alternate procedures or treatments and the substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this or a similar community who perform similar treatments or procedures; OR B. That I, considering all the surrounding circumstances, would have undergone such treatments or procedure had I been advised by my dentist as described in paragraph A above.
- B. I authorize the 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.
- C. I understand that all 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 other arrangements have been made in advance. In the even payments are not received by the agreed upon dates, I understand that a financing charge may be added to my account or that my account may be sent to a collection agency.

Patient or authorized person on behalf of Patient : _____

Date: _____

PAYMENT POLICY

Thank you for choosing us for your dental health needs. We are committed to providing extraordinary care for extraordinary patients. In order to answer your questions regarding patient and insurance responsibility for services rendered, we have developed the following payment policy.

Please read it, ask us any questions that you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance** – We participate in many PPO plans. If you are not insured by a plan in which we are a participating in-network provider, **payment in full is expected at each visit** unless other arrangements have been made in advance. If you are insured by a plan that we participate with but we are unable to verify your coverage, payment in full for each visit is required until that verification can be obtained. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you have regarding your coverage.
2. **Co-payments and Deductibles** – Any co-payments and applicable deductibles must be paid **at time of service**. This arrangement is part of your contract with your insurance company.
3. **Non-covered Services** – We believe in providing only the best treatment for our patients. Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of visit.
4. **Proof of Insurance** – All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims Submission** – As a courtesy, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage Changes** – If your insurance changes, please notify us **BEFORE** your next visit so we can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. The amount due will then become your responsibility.
7. **Nonpayment** – Please be aware that if your account becomes 90 days past due, you will receive notice that you are being sent to collections and you as well as your immediate family members will be dismissed from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative dental care. During that 30 day period, our dentist will only be able to treat you on an emergency basis.
8. **Missed Appointments** – Our policy is to charge for missed appointments not cancelled within the specified amount of time. **You must call by 5 pm on the business day specified** to avoid a broken appointment fee of up to \$100.00 Please note that the office is closed on Fridays and therefore, notice for a Monday appointment must be provided before 5 pm on the preceding Thursday unless otherwise specified on your appointment confirmation form.
9. **Returned Check Policy** – Checks returned for insufficient funds must be paid **within seven days** of notification. Depending on the amount of the check returned, a fee ranging from \$35 to \$50 in addition to the amount of the check will be charged. Payment must be made with cash or money order only. No credit card payments will be accepted. Failure to pay in full within the time specified will result in a worthless check affidavit being filed with the Apopka Police Department.

IN ORDER TO MAINTAIN FAIR AND EQUITABLE TREATMENT FOR ALL OUR PATIENTS, THIS POLICY IS REGARDLESS OF REASON.

These charges will be your responsibility and billed directly to you. Please help us to serve you better by only scheduling definite appointments.

Thank you for understanding our payment policy. Please let us know if you have any questions.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date

HIPAA Notice of Privacy Practices

RICHARD PETRILLI, DMD PA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing, marketing

And fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to dental school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then Have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____ Date: _____