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 25 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 of 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 themouth?	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
407-884-1846

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#: _____

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: _____

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:

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**

HIPPAA

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at 407-884-1846 or info@petrillidmd.com or 1585 Rock Springs Rd, Apopka, FL 32712
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other govt. requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective October 1, 2013
- Annette – HIPPAA compliance officer info@petrillidmd.com / 407-884-1846
- We never market or sell personal information to any other entity.

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:_____