WELCOME TO OUR PRACTICE!

On behalf of the entire team at Vitelli Comprehensive Dentistry, let us welcome you to our practice! We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional and extraordinary. You may discover that we are different than the average dental practice. When you visit our office, you will find a calm and relaxing environment. Our team is attentive and friendly. All of our dental treatments are designed to be conservative, comfortable and long lasting. The practice's greatest strength lies in our mission to prevent most oral conditions through patient education and instruction.

Enclosed in this welcome packet are several important documents that will explain our dental practice philosophy and policies along with several questionnaires to help us in making your transition to Vitelli Comprehensive Dentistry as smooth as possible. **Please have these papers filled out and signed prior to your first appointment.**

For more information regarding the services we offer and to meet the entire team, please visit us online at www.vitellidentistry.com. We look forward to serving all of your dental needs!

Yours truly in good oral health.

Adam Vitelli, DMD

Patient Information

Patient Name_____ Date: _____
Last First MI (Preferred Name)

Gender_____ Family Status: _____

Social Security #_____ Birth Date: _____ Email: _____

Phone (Home):_____ (Work):_____ (Cell):_____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Hypo-Thyroid
- ☐ Hyper-Thyroid

OTHER:

- ☐ _____
- ☐ _____

OFFICE USE:

BP:
_____ / _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

  If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No

  If yes, please explain: _____

  - Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain: _____

- How often do you have dental examinations? _____

- Have you had any Periodontal (gum), Oral Surgery, or Orthodontic Treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- Do you experience any Clicking, Popping or Discomfort in your Jaw? ☐ Yes ☐ No
- Do you Clench or Grind your teeth? ☐ Yes ☐ No
- Have you ever had an upsetting dental experience? ☐ Yes ☐ No
- Do you use Tobacco Products? ☐ Yes ☐ No

- **(Women ONLY)** Are you or could you be pregnant or nursing? ☐ Yes ☐ No

How do you feel about the appearance of your smile?

_____
_____
_____

Do you have any concerns or issues that you would like to have addressed during today's visit? If yes, please explain:

_____
_____
_____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date:** _____

Signature of patient, parent or guardian

Reviewed by:	**Date:**
Referred by:	

Medication List

OFFICE USE:

□ No BOP, P < 3mm, Healthy

□ Isolated BOP, P 3mm-4mm < 30% Inflammation, Gingivitis

□ BOP > 30%, P > 3mm, 30% or more Inflammation, No Bone Loss, Gingivitis

□ BOP > 3mm with bone loss requires further treatment

□ Unable to Probe

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The Practice has a notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserved the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore payment in full is required at the time services are rendered.

Information SHARING: Please list the individuals we can share your personal information with other than healthcare providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

This HIPAA Consent was signed by (Signature) *Today's Date*

_____

Relationship to patient (if other than patient)

HOW YOUR INSURNACE AND VITELLI COMPREHENSIVE DENTISTRY WORK TOGETHER

Our goal at Vitelli Comprehensive Dentistry is to provide you the best dental care and help to minimize your out of pocket expense. One component of this is helping you maximize the use of your insurance benefits. Vitelli Comprehensive Dentistry is a pre-payment office for any dental treatment. Please ask us any questions you may have after you read the information below.

Commonly Asked Questions:

Q: DO YOU ACCEPT MY INSURANCE?

A: Vitelli Comprehensive Dentistry is an in-network provider with several insurance plans. Please ask about the specific plans. With all insurance plans, we are happy to file the claim for you and will accept assignment of benefits if your plan allows. Accepting assignment of benefits does not mean that we accept whatever the insurance company pays as full payment. Most insurance plans require the patient to pay a deductible, and a portion of the cost.

Q: HOW MUCH WILL MY DENTAL INSURANCE PAY?

A: Once we have the opportunity to verify your dental insurance coverage and obtain a breakdown of benefits, we are then able to estimate your payment portion based on that information, however, it is **ONLY AN ESTIMATE**. It is impossible for us to give you a guarantee of what the insurance company will pay at the time of service. If we are unable to verify your insurance coverage, you are responsible for payment in full of all fees associated with your treatment at each visit.

Q: INSURANCE DIDN'T PAY, NOW WHAT?

A: Ultimately, you are responsible for all charges occurred in our office. We file your insurance claims as a courtesy to you. It is important that you be aware that the insurance you have is a legal contract between **YOU** and **YOUR** insurance company. Our office is not and cannot be a part of that legal contract. If your insurance company does not pay a claim within 60 days, Vitelli Comprehensive Dentistry reserves the right to request payment in full for services from you and let you collect insurance funds that are due to you. Additionally, dental insurance is designed to defray the cost of your dental treatment. **It is not intended as a total payment for services and should not be used to determine the type or amount of treatment you receive.**

Q: I THOUGHT I PAID MY PORTION, BUT I STILL OWE MORE, WHY?

A: We base your ESTIMATED out of pocket expense on the benefit verification information that we receive from your insurance company, but there are many factors that can affect this estimate. There may be an annual deductible that must be met (individual or family), or you may have received treatment in another office prior to visiting Vitelli Comprehensive Dentistry. You might need to see a specialist for care, which may use a portion or all of your annual maximum dental benefits. Insurance companies do not (and cannot in most cases) notify Vitelli Comprehensive Dentistry of changes to your benefits, they only notify you. If any of those situations apply to you, please let us know as soon as possible.

Q: WHAT IS UCR?

A: UCR stands for Usual, Customary and Reasonable. It is a term created by the insurance companies to define what they are willing to pay for a particular procedure. It is our experience that these amounts can be substantially lower than the actual fees Dr. Vitelli charges.

ASSIGNEMENT OF BENEFITS

I authorize my insurance company to pay Vitelli Comprehensive Dentistry all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance claim submissions.

I authorize Vitelli Comprehensive Dentistry to release all information necessary to secure payment of insurance benefits.

I understand that I am financially responsible for all fees regardless of whether they are covered by insurance.

Vitelli Comprehensive Dentistry will do everything possible to assist you in filing claims and following up on claims so that you can maximize your benefits.

I have read, understand and accept the terms of the above outlines policies for insurance handling and financial commitments that I may incur as a result of treatment at Vitelli Comprehensive Dentistry.

Patient/Guardian Signature_____Date_____

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GENERAL DENTISTRY CONSENT FORM

Dentistry is not an exact science and reputable practitioners cannot guarantee results. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during examination but were found during treatment. For example, root canal treatment may be needed during routine restorative procedures. Any change in treatment plan may result in additional fees.

Guarantees and assurances cannot be made by anyone regarding the dental treatment which you have requested and authorized. It is essential that you keep your appointments and cooperate in your treatment to help insure the best possible result. Please read the following and initial and sign where noted.

SERVICES THAT MAY BE PROVIDED

1. DRUGS, MEDICATIONS AND ANESTHETICS

Antibiotics, analgesics, natural supplements and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock. Injections of local anesthetics can cause paresthesia (numbness) of teeth, lips and surrounding tissues. Though quite rare, this numbness can sometimes be permanent. Studies have shown that Bisphosphonate (ex. Fosomax) therapy for osteoporosis can compromise treatment results.

(Initials_____)

2. FILLINGS

Care must be exercised in chewing on filled teeth, especially on large fillings and during the first 24 hours, to avoid breakage. A more extensive restorative procedure than originally diagnosed may be necessary, due to more decay than anticipated. Sensitivity can occur following a newly placed filling and will usually go away with time.

(Initials_____)

3. CROWNS, BRIDGES AND VENEERS

These restorations involve permanent alteration to the tooth structure. It is not always possible to match the color of the natural teeth exactly with artificial teeth. Temporary restorations may come off easily. Care must be taken to ensure that they are kept on until the permanent restorations are delivered. The final opportunity to make changes to the new crowns, bridges or veneers (including the shape, fit, size and color) will be before cementation. It is necessary to keep the appointment for permanent cementation. Excessive delays may allow for tooth movement, necessitating the remaking of the restoration and additional charges may be incurred.

(Initials_____)

4. DENTURES (FULL AND PARTIAL)

The wearing of dentures can be difficult. Sore spots, altered speech and difficulty in eating are common problems. Due to jaw ridge loss, retention of full dentures can be a problem. Immediate dentures may require considerable adjusting and several reliens. A permanent reline will be needed later (this is not included in the denture fee). You are responsible for the delivery of the dentures. Failure to do so may result in poorly fitting dentures and remakes will require additional charges. Failure to wear partial dentures every day will likely lead to tooth movement, resulting in a partial that no longer fits.

(Initials_____)

5. PERIODONTAL DISEASE

Periodontal disease affects the gums and bone which support the teeth. It is a serious, progressive infection, causing breakdown of the gyms and bone and eventual loss of teeth. It is best treated in its early stage. Treatment options may include gum surgery, extractions and replacements. Undertaking any dental procedure may have a future adverse effect of the periodontia.

(Initials_____)

6. ENDODONTIC TREATMENT (ROOT CANAL)

Although over 90% effective, there is no guarantee that root canal treatment will succeed, and complications can occur from the treatment. Endodontic files and reamers are very fine instruments and can separate during use. Additional surgical procedures may be necessary following root canal treatment. Despite all efforts to save it, the tooth may still be lost.

(Initials_____)

7. REMOVAL OF TEETH (EXTRACTIONS)

Teeth may need to be extracted for various reasons, such as non-restorability, lack of bone support, part of orthodontics treatment, impactions, etc., There are alternatives to the removal of treatable teeth and these options including, root canal treatment, periodontal treatment and crowns. Removal of teeth does not always remove the infection, if present, and further treatment may be necessary. There are risks involved in having teeth removed, including, but not limited to pain, swelling, spread of infection, dry socket, loss of feeling in the teeth, lips, tongue and surrounding tissues (which is usually temporary, but in rare cases is permanent), sinus involvement and jaw fracture. If you prefer, we can give you a referral to an oral surgeon. If complications arise during or following treatment, referral to a specialist may be needed, requiring further treatment and additional cost.

(Initials_____)

8. MISSED APPOINTMENTS

Vitelli Comprehensive Dentistry strives to value your time. We do our very best to not run behind or to make you wait in the waiting room for your appointment. This is only possible if patients also respect the scheduled appointment time. We ask for 48 hours (two full business days) notice for you to move your appointment. If an appointment is cancelled or moved without 48 hour notice, you may be billed a $50 charge.

SEDATION APPOINTMENTS: If you cancel within 48 hours of your appointment or do not show up, $1,000 of your pre-payment is non-refundable. We require 48 hours cancellation notice.

(Initials_____)

Signature of Patient Print Name Date

SLEEPINESS SCALE

EPWORTH SLEEPINESS SCALE

Name:_____ DOB:_____ Date:_____

This questionnaire was developed to determine the level of daytime sleepiness in individuals. It has become one of the most frequently used methods for determining a person's average level of daytime sleepiness. You should review your responses with your doctor.

Please rate how likely you are to doze or fall asleep in the following situations by selecting the response that best applies. If you have not done some of these activities recently, select what would most likely happen if you were in that situation.

0 Would ***never*** doze

1 ***Slight*** chance of dozing

2 ***Moderate*** chance of dozing

3 ***High*** chance of dozing

	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (eg, a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Total Score:				

Vitelli COMPREHENSIVE DENTISTRY