**Smiles of Trinity Family Dentistry**
**8925 Mitchell Blvd.**
**New Port Richey, FL  34655**
**(727) 376-6969**

# Welcome to our practice!

**We think you'll find us a little different in small, but important ways.**

**First we'll involve you--depend on you, actually--during the course of your treatment.  Dental health is a team enterprise with one collective goal--nurturing your teeth, mouth, and gums to simply be the best they can be.**

**Maybe you've neglected your dental health for a bit too long, or maybe a past experience has left you with apprehension when it comes to dental care.  Dental technology has come a long way from what you might remember.  Welcome to comfortable dentistry.  REALLY.**

**If you have questions about your treatment, or any other concerns, we always take the time to discuss these problems with you.  So you can relax and feel good about your visit with us.  Again, WELCOME.**

**Very truly yours,**

**Gianni Franceschi, D.D.S. and staff**

# WELCOME

Smiles Of Trinity Family Dentistry
Gianni Franceschi D.D.S.
8925 Mitchell Blvd.
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Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask-we will be happy to help.

## Patient Information (CONFIDENTIAL)

Soc. Sec#_____

Date_____

Home Phone_____

Cell_____ Work_____

Birth date:_____

Last Name_____ First Name_____ Middle_____

Address_____ City_____ State_____ Zip_____

Please Circle One Minor Single Married Divorced Widowed Separated

Email Address_____ Patient's or Parent's Employer_____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Phone_____

Whom May We Thank For Referring You?_____

Person to Contact in Case of a Emergency_____ Phone_____

## Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Employer_____ Phone_____ SSN#_____ Home Phone_____

Is this Person Currently a Patient in our Office? YES NO Driver's License #_____

For your convenience, we offer the following methods of payment. Please circle the option you prefer. Payment in full due at each appointment. CASH PERSONAL CHECK VISA / MASTERCARD

## Insurance Information

Name of Insured_____ Relationship to Patient_____

Birth date_____ SSN#_____ Home#_____

Name of Employer_____ Work#_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group#_____ Policy/ID #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of Patient ( or parent if minor ) Date

OVER PLEASE

Smiles Of Trinity Family Dentistry, Inc.

# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| | | | |
|---|---|---|---|
| Are you under a physician's care now? | Yes | No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation? | Yes | No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury? | Yes | No | If yes, please explain: _____ |
| Are you taking any medications, pills, or drugs? | Yes | No | If yes, please explain: _____ |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes | No | _____ |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes | No | _____ |
| Are you on a special diet? | Yes | No | |
| Do you use tobacco? | Yes | No | |
| Do you use controlled substances? | Yes | No | |

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes | No | Cortisone Medicine | Yes | No | Hemophilia | Yes | No | Radiation Treatments | Yes | No |
| Alzheimer's Disease | Yes | No | Diabetes | Yes | No | Hepatitis A | Yes | No | Recent Weight Loss | Yes | No |
| Anaphylaxis | Yes | No | Drug Addiction | Yes | No | Hepatitis B or C | Yes | No | Renal Dialysis | Yes | No |
| Anemia | Yes | No | Easily Winded | Yes | No | Herpes | Yes | No | Rheumatic Fever | Yes | No |
| Angina | Yes | No | Emphysema | Yes | No | High Blood Pressure | Yes | No | Rheumatism | Yes | No |
| Arthritis/Gout | Yes | No | Epilepsy or Seizures | Yes | No | High Cholesterol | Yes | No | Scarlet Fever | Yes | No |
| Artificial Heart Valve | Yes | No | Excessive Bleeding | Yes | No | Hives or Rash | Yes | No | Shingles | Yes | No |
| Artificial Joint | Yes | No | Excessive Thirst | Yes | No | Hypoglycemia | Yes | No | Sickle Cell Disease | Yes | No |
| Asthma | Yes | No | Fainting Spells/Dizziness | Yes | No | Irregular Heartbeat | Yes | No | Sinus Trouble | Yes | No |
| Blood Disease | Yes | No | Frequent Cough | Yes | No | Kidney Problems | Yes | No | Spina Bifida | Yes | No |
| Blood Transfusion | Yes | No | Frequent Diarrhea | Yes | No | Leukemia | Yes | No | Stomach/Intestinal Disease | Yes | No |
| Breathing Problem | Yes | No | Frequent Headaches | Yes | No | Liver Disease | Yes | No | Stroke | Yes | No |
| Bruise Easily | Yes | No | Genital Herpes | Yes | No | Low Blood Pressure | Yes | No | Swelling of Limbs | Yes | No |
| Cancer | Yes | No | Glaucoma | Yes | No | Lung Disease | Yes | No | Thyroid Disease | Yes | No |
| Chemotherapy | Yes | No | Hay Fever | Yes | No | Mitral Valve Prolapse | Yes | No | Tonsillitis | Yes | No |
| Chest Pains | Yes | No | Heart Attack/Failure | Yes | No | Osteoporosis | Yes | No | Tuberculosis | Yes | No |
| Cold Sores/Fever Blisters | Yes | No | Heart Murmur | Yes | No | Pain in Jaw Joints | Yes | No | Tumors or Growths | Yes | No |
| Congenital Heart Disorder | Yes | No | Heart Pacemaker | Yes | No | Parathyroid Disease | Yes | No | Ulcers | Yes | No |
| Convulsions | Yes | No | Heart Trouble/Disease | Yes | No | Psychiatric Care | Yes | No | Venereal Disease | Yes | No |
| | | | | | | | | | Yellow Jaundice | Yes | No |

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

SMILES OF TRINITY FAMILY DENTISTRY

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

## SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

## SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**Include completed Consent in the patient's chart.**

# Smiles of Trinity Family Dentistry

## Summary of Privacy Practices

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length notice is available upon request.

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more details please refer to the Notice of Privacy Practices):

| | |
|---|---|
| For Medical treatment | For research |
| To obtain payment for our services | To avert a serious threat to health or safety |
| In emergency situations | For worker' compensation programs |
| Response to requests arising out of lawsuits and/or other disputes | |

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our practice administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain right regarding the information we maintain for you. These rights include:

| | |
|---|---|
| The right to inspect and copy | The right to request restrictions |
| The right to amend | The right to a paper copy of this notice |
| The right to an accounting of disclosures | The right to request confidential communications |

If you would like a more detailed information about these rights, please see the Notice of Privacy Practices posed in the reception room or you may request a paper copy from the receptionist.

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Gianni Franceschi D.D.S.
Shahenaz Suliman, D.M.D.
8925 Mitchell Blvd.
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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT**

I, _____, have received a copy of this office's Notice of Privacy Practice.

_____
Please Print Name

_____
Signature

_____
Date

**** FOR OFFICE USE ONLY***

_____

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: (check one)

Individual refused _____

Communications barriers prohibited obtaining the acknowledgement _____

An emergency situation prevented us from obtaining acknowledgement _____

Other ( Please specify )

_____

_____

_____

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# 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, must be paid for in full 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 patients account. You will also be expected to pay any benefit proceeds from your insurance to this office. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Most misunderstandings about insurance can be avoided if you understand what your policy provides. Many insurance policies pay according to a schedule of benefits that is based on a various criterion. This office charges fees which are reasonable in this community. Not all insurance companies will pay 100% of our charges. The patient (and/or spouse/guarantor) is responsible to pay all sums unpaid by insurance. Benefits are only determined once a claim is received by the insurance company, there are NO verbal guarantees given by the insurance company. Any determination of benefits verbally and/or written given by any staff member is not guaranteed.

A service charge of 1.5% 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 6 months from the date of the patients examination.

If you are unable to keep your appointments we require 24 hours notice for cancellations. If you give less than 24 hours notice there will be a $100 charge for appointments scheduled longer than 1 1/2 hours. If appointment scheduled is less than 1 1/2 hours there will be a $40 charge.

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 her/his assignee at the time said services are rendered, or within 5 days of billing if credit shall be extended. I further agree that the reasonable value said services shall be 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. if it becomes necessary to collect any sum due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all costs of collection, including attorney's fees, whether suit is filed or not.

I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form. The patient/legal guardian authorizes the release of information acquired in the course of treatment as necessary to file insurance claims.

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

_____ _____
Signature of guarantor of payment/responsible party Date

_____ _____ _____
Print Name Date Relationship to Patient

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date:_____