**Patient Registration**

J. Andrew Carletti, DDS / Lesley Maxwell, DDS / Cameron Craig, DDS

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last Preferred Name

Birthdate\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Has anyone in your family been seen in our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tulsa / Sapulpa

Name Circle

SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work# (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single\_\_\_\_Married\_\_\_\_Divorced\_\_\_\_Widowed\_\_\_\_ SpousesName:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_Home Number(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Receive text message? Yes\_\_\_No\_\_\_\_Fax Number(\_\_\_)\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Who told you about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person Responsible for Account if different than above:** Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_Home #(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work#(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance? Yes \_\_\_No\_\_\_With whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Card holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance?Yes\_\_\_No\_\_\_ With whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Card holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nearest Relative not living with you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_Phone(\_\_\_)\_\_\_\_\_\_\_\_\_\_Are you currently having dental problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your concerns? Check as many as applicable: (Pain Avoidance)\_\_\_\_ (Appearance)\_\_\_\_\_\_ (Losing Teeth)\_\_\_\_\_ (Gum/Periodontal disease)\_\_\_\_ (Cavities) \_\_\_\_(Oral Cancer)\_\_\_\_\_(Wasting/Exceeding Dental Insurance Limits)\_\_\_\_\_ (Your General Health)\_\_\_\_(Routine Checkup) \_\_\_\_ (Cleaning) \_\_\_\_ (Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Circle Yes or no to the following questions:**

1. Are you presently under the care of a physician? …………………………………………………………………………….….….Yes No
2. Have you ever had high blood Pressure? ………………………………………………………………………..…………....……..Yes No
3. Has a physician ever said you had heart trouble? ………………………………………………..…………………………..….…..Yes No
4. Have you had a recent surgery? Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_……………………….……………………………………………..….…..Yes No
5. Do you have artificial joints? What joint?\_\_\_\_\_\_\_\_\_\_\_\_\_...……………..……………………………………..……………...…...Yes No
6. Have you ever had abnormal bleeding following a cut or extraction? …………………………..……………………………...…..Yes No
7. Has a physician or dentist ever said you had a tumor or cancer? ……………………………………………………………....…...Yes No
8. Are you allergic to penicillin, codeine or any other medicine? …………………………….…………………………….………....Yes No
   1. If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Is the patient allergic to anything other than medicine? (e.g. latex or metals)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_..........................Yes No
10. Are you or have you ever taken bisphosphate or medicine for osteoporosis?.....................................................................................Yes No
11. Have you ever been diagnosed with sleep apnea?................................................................................................................................Yes No
12. Do you wear a CPAP? ……………………………………………………………………………………………………………….Yes No
13. Do you have acid reflux or GERD?......................................................................................................................................................Yes No

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| --- | --- |
| **Do you have or have ever had** | **Please list all medications below:** |
| Rheumatic fever………………………………..…Yes No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |
| Heart disease/pacemaker…………….………..…..Yes No |  | |
| Epilepsy or convulsions……………….……….….Yes No |  | |
| Asthma or hay fever………………….…….….….Yes No |  | |
| Tuberculosis……………………..…….…...….….Yes No |  | |
| Diabetes? How long\_\_\_\_\_……………….....…….Yes No |  | |
| Kidney trouble……………………..…………..….Yes No |  | |
| Liver trouble or jaundice…………………..…..….Yes No  Do you use any kind of tobacco?\_\_\_\_\_\_\_..............Yes No  **Dental History**  Had any periodontal treatment…………………....... Yes No  Gums bleed while brushing or flossing…….................Yes No  Feel pain to any of your teeth……………………........Yes No  Head, neck or jaw injuries………………………..…...Yes No  Frequent headaches……………………………...….....Yes No  Had a difficult extraction in the past…………....…......Yes No  Had any orthodontic treatment………………...…........Yes No  Teeth sensitive to hot or cold liquid/foods……....….....Yes No  Teeth sensitive to sweet or sour liquids/foods…....…....Yes No  Clicking, difficult chewing, difficult opening/closing....Yes No  Clench or grind your teeth……………………………...Yes No  Prolonged bleeding following an extraction…………...Yes No  Wear denture or partials...........................................…....Yes No |
| Thyroid trouble or goiter……………………....….Yes No |
| Syphilis……………………..………....……….….Yes No |
| Fainting or dizziness………….…….………...…...Yes No |
| Glaucoma…………………….………………..….Yes No |
| Arthritis……………………………………..…….Yes No |
| HIV/AIDS…………………………………..…….Yes No |
| Stroke……………………..…………………..…...Yes No |
| Stomach ulcer……………………………….….….Yes No |
| Heart murmur………………………….…....….….Yes No |
| Prostate trouble…………………………………….Yes No |
| Hepatitis……………………..……………..……...Yes No |
| Eczema or hives? ………………………...……….Yes No |
| Psychiatric treatment? ………………………...….Yes No |
| Are you pregnant? ……………………..…….…....Yes No  Do you have anemia? ……………………….…….Yes No  **Authorization and Release**  I authorize Dr. Carletti to obtain medical clearance and to share medical records in order to expedite treatment, and assist in diagnosis. I have received a copy of the Notice of Privacy Practiced and I have read the information.  X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of patient  I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. 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  X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of patient |
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**ALL PATIENTS**   
PLEASE READ THIS CAREFULLY

**Insurance**

By my signature below, I acknowledge that I understand that the amount quoted as my portion (the portion of my bill that insurance does not pay) was based on telephone verification with my insurance company only. I understand that my insurance company does not view this telephone correspondence as a promise to pay, and thus quoted benefits are an estimate only. This means that once the insurance pays the claim, I may have a refund coming, or I may owe additional fees. I understand that sometimes insurance companies say one thing on the phone, and in actuality pay the claim much differently. I understand that I am responsible for any amount not paid by m insurance company, regardless of the estimate I receive in advance as to my portion of the bill. I also acknowledge by my signature below that I have been given the opportunity to ask questions of my doctor’s staff concerning billing, and I have had/will have the opportunity to call my own insurance company regarding payment of this claim.

**Appointment Policy**

Our practice is dedicated to your quality care and is pleased to reserve an appointment time for you. Because our patients have requested, we have adopted office appointment guidelines that allow our patients to pre=reserve and schedule convenient appointment times. Many patients need our services and in order to accomplish this in an efficient manner, we require a minimum of 24 hour notice for any appointment changes. A charge may be applied for broken and missed appointments without advance notification.

*I understand that payment is due at time of service I will pay today by*

*CASH [ ] CHECK [ ] CREDIT CARD [ ]*

*I verify that the proceeding information is true. I authorize the release of information to my insurance company. I will allow John A Carletti, D.D.S. and his associates to discuss my conditions with my physicians and to request medical information from them. I also acknowledge that I have been given or offered a copy of the offices “Notice of Privacy Practices”.*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient

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**Carletti Dental Office Values**

**We Value…**

**Quality**

We aspire to provide a high quality dental experience for our patients. We value excellence, attention to detail, have high standards in aesthetics, and constantly do our best to improve dental health. We strive to change our patients’ lives by creating healthy and beautiful smiles.

**Integrity**

We value personal integrity, honesty, and fairness. We intend to always try to do the right thing involving our coworkers, our patients and our families. We are determined to live by the Golden Rule, and we strive to be fair in our services and our financial arrangements.

**Patient-Oriented Customer Service & Care**

We intend to consistently exceed the expectations of our patients. We are committed to providing exceptional, comfortable, and accommodating service as we anticipate our patients’ needs, meet these needs, and leave our patients feeling our genuine care and concern. We value a climate that is characterized by friendliness, fun, and relaxation.

**Cutting-Edge Technology**

We place great importance on utilizing the latest technological developments in dentistry. We value continuous improvement as we learn and grow, and we strive to demonstrate leadership in our community.