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
   a. 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

Do you have or have ever had

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
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

Please list all medications below:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

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

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

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.