Patient Registration

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

Name: _____ Birthdate: _____ Social Security #: _____
FIRST NAME MI LAST NAME PREFERRED NAME

Address: _____ City: _____ Zip: _____

Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Employer: _____ Occupation: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Spouse: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Occupation: _____

Work Phone: _____ Cell Phone: _____ Email: _____

If Patient is a minor, please complete the following:

Name of person responsible for this account: _____ Relatonship to Patient: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Occupation: _____ Work Phone: _____

Health Care Providers:

General Physician: _____ City: _____ Emergency Contact: _____ Phone: _____

Other people involved in dental care (periodontist, endodontist, etc): _____

Other Physicians involved in healthcare (cardiologist, orthopedic surgeon, etc): _____ City: _____ Phone: _____

Dental Insurance Information:

Primary Insurance Company: _____

Policy Holder: _____ DOB: _____

Patient's Relationship to Policy Holder: _____

Social Security # or ID#: _____

Secondary Insurance Company: _____

Policy Holder: _____ DOB: _____

Patient's Relationship to Policy Holder: _____

Social Security # or ID#: _____

Medical Insurance Information:

Primary Insurance Company: _____

Policy Holder: _____ DOB: _____

Patient's Relationship to Policy Holder: _____

Social Security # or ID#: _____

Secondary Insurance Company: _____

Policy Holder: _____ DOB: _____

Patient's Relationship to Policy Holder: _____

Social Security # or ID#: _____

We would like to introduce you to our Smile Reminder Program:

Smile Reminder is a way that we can make it easier for you to remember your appointment by sending you reminders via text message or email. Its benefits include being able to read the messages at your convenience without the interruption of a phone call. You are also able to confirm your appointment electronically. We understand your time is valuable and it's sometimes challenging to receive our calls. Do you consent to receiving text and/or email reminders? We will utilize the contact information provided above? ☐ YES ☐NO

I, (Print Name) _____, hereby grant permission for Carletti Dentistry to discuss and/or release information concerning my diagnosis, or information to or in my records, or any dental information that the aforementioned entity may have on file as it pertains to me including but not limited to billing, benefit inquiries, claims, appeals, and complaints, to the following individual(s) in compliance with the required HIPPA guidelines.

I authorize the following individual(s) to review and approve treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Date: _____
FIRST NAME MI LAST NAME

Current Medications/Supplements, Dosage and Reason for:

Preferred Pharmacy: _____

Allergies, Drug Allergies & Symptoms: _____

Although some of the following questions may seem unrelated to your teeth, they are associated with proper management of your oral health and are confidential.

Do you have or have you had any of the following:

Heart Problems……YES NO
If yes, please describe: _____
High Blood Pressure……YES NO
Low Blood Pressure……YES NO
Pacemaker……YES NO
Artifical Heart Valve……YES NO
Joint Replacement……YES NO
If yes, please describe:
Is an antibiotic required before treatment……YES NO
If so, what type/dosage? _____
Easy Bruising……YES NO
Abnormal Bleeding……YES NO
Frequent Nose Bleeds……YES NO
Anemia……YES NO
History of Blood Transfusion……YES NO
History of Stroke or TIA……YES NO
Sinusitis……YES NO
Asthma……YES NO
Tuberculosis……YES NO
COPD……YES NO
Hepatitis, Type: _____ YES NO
Liver Problems……YES NO
Kidney Problems……YES NO
Bladder Problems……YES NO
Ulcers……YES NO
Gallstones or Gallbladder Problems……YES NO
Arthritis……YES NO
Back or Neck Pain……YES NO
Osteoporosis……YES NO
Osteopenia……YES NO
History of Fainting……YES NO
History of Seizures……YES NO
If yes, Date of last seizure? _____
Epilepsy or other neurological disorder……YES NO
If other, what? _____
History of Head Trauma……YES NO
Frequent or Severe Headaches or Migraines……YES NO

Thyroid Concerns……YES NO
Diabetes, Type: _____ HbA1c: _____ YES NO
Family History of Diabetes……YES NO
Excessive Thirst/Dry Mouth……YES NO
Oral Herpes or Cold Sores……YES NO
HIV+ or AIDS……YES NO
Have you received/donated an organ?……YES NO
Have you had cancer?……YES NO
If yes, what type: _____
If yes, medication/treatment: _____
Have you taken Fosamax/Boniva/Actonel/Zometa?……YES NO
Depression or Anxiety?……YES NO
History of Alcohol/Drug Abuse……YES NO
Do you smoke/ use smokeless tobacco?……YES NO
If yes, how often? _____
Have you been diagnosed with sleep apnea?……YES NO
Do you wear a CPAP?……YES NO
Have you been told you snore?……YES NO
Been told you have periodontal disease (gum)……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 (braces)……YES NO
Teeth sensitive to hot or cold……YES NO
Teeth sensitive to sweet or sour……YES NO
Difficulty chewing/opening/closing……YES NO
Clench or grind your teeth……YES NO
Prolonged bleeding following an extraction……YES NO
Wear denture or partials……YES NO
Do you have acid reflux or GERD?……YES NO

Women:

Pregnant, Due Date: _____
Are you nursing?……YES NO
Other Medical Conditions or recent surgery: _____

Do any members of your family have or have they had in the past (please indicate relationship to you):

☐ Dentures ☐ Periodontal Disease (Gum)

Please list any other comments regarding your teeth, mouth or dental history: _____

ALL PATIENTS

PLEASE READ THIS CAREFULLY

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

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.