STUNNINGSMILES
Custom Smiles & Healthy Mouths

On behalf of the entire team at Stunning Smiles of Las Vegas - Excellence in Dentistry, let me 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 from the average dental practice. When you visit our office you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received. It is for these simple reasons that we provide Excellence in Dentistry.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed questionnaire that should be filled out prior to your first appointment with Dr. Racanelli.

Be sure to visit our website at *www.LVStunningSmiles.com.* We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Richard A. Racanelli, DMD

Richard A. Racanelli, DMD

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REGISTRATION AND HEALTH HISTORY

Date: _____

First Name: _____ M.I. ____ Last Name: _____ ◯ male ◯ female Date of Birth: _____ Age: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Social Security#: _____

Email Address: _____ Emergency Contact: _____

Marital Status: ◯ Married ◯ Single Student: ◯ Full-time ◯ Part-time ◯ N/A Occupation: _____

What would you prefer to be called? _____ Who may we thank for this referral? _____

Family Physician: _____ Phone#: _____

Dental Insurance Carrier: _____ ID#: _____ Group #: _____

☐ Check this box ***ONLY*** if the Insured person *(the person receiving dental service)* is the same as applicant above. If not, enter Insured info below.

Name of Insured: _____ Insured's SS#: _____ Insured's Date of Birth: _____

Relationship to Insured: _____

Employer of Insured: _____ ◯ Full-time ◯ Part-time ◯ Retired Phone#: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Who is financially responsible for this account? _____ Phone#: _____

Please select Y = Yes or N = No if you have any of the following conditions:

◯Y ◯N - Rheumatic Fever
◯Y ◯N - Heart Disease
◯Y ◯N - Heart Murmur (or MVP)
◯Y ◯N - High Blood Pressure
◯Y ◯N - Tuberculosis
◯Y ◯N - Use Oral Contraceptives
◯Y ◯N - Artificial Joint / Heart Valve
◯Y ◯N - History of Endocarditis

◯Y ◯N - Thyroid Disease
◯Y ◯N - Anemia
◯Y ◯N - Asthma
◯Y ◯N - Diabetes
◯Y ◯N - Are you nursing
◯Y ◯N - Might you be pregnant
◯Y ◯N - Hepatitis Type: ☐A ☐B ☐C
◯Y ◯N - Radiation Therapy: Head / Neck

◯Y ◯N - Seizure Disorder
◯Y ◯N - Kidney Disease
◯Y ◯N - Venereal Disease
◯Y ◯N - Bleeding Problems
◯Y ◯N - Cancer
◯Y ◯N - Aids/HIV
◯Y ◯N - Eating Disorders
◯Y ◯N - History of HPV

Other conditions not listed: _____

Are you allergic to latex, soy, egg, milk, dairy or nuts products? _____

List any antibiotics, anesthetics or other drugs you are allergic to: _____

List all prescription/OTC medications, vitamins and/or supplements you are presently taking: _____

_____

Do you have any disease, organ transplant, or take any medication which may depress your immune system? _____

Do you have, or have you ever had clicking, popping or pain in your tempromandibular joints (TMJ)? _____

Have you been hospitalized in the past five years? ◯ Yes ◯ No If yes, why? _____

Do you take aspirin on a daily basis? ◯ Yes ◯ No If yes, why? _____

Are you under a physician's care presently? ◯ Yes ◯ No If yes, why? _____

Have you ever been a drug or substance abuser? ◯ Yes ◯ No Do you smoke? ◯ Yes ◯ No How much? _____

Is there anything you would like to discuss with the Doctor in private? _____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to Stunning Smiles of Las Vegas unless otherwise indicated.

Signature: _____ **Date:** _____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms as well as releasing Richard A. Racanelli, DMD to utilize any dental photographs for lecturing and educational purposes.

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DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? ◯ Yes ◯ No

If so, explain: _____

Has anything happened with a previous dental experience that has influenced your decision to return? _____

_____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? ____ time(s) a day How often do you floss? ____ time(s) a day

What type of brush do you use? ◯ Manual ◯ Powered

Do you avoid brushing any part of your mouth because of pain? ◯ Yes ◯ No If yes, what part? _____

Which foods cause you twinges of pain: ☐ Hot ☐ Cold ☐ Sweet ☐ Sour ☐ None

Do your gums feel tender or swollen? ◯ Yes ◯ No

Do you chew on only one side of your mouth? ◯ Yes ◯ No If yes, explain: _____

Do you clench or grind your jaws while sleeping or during the day? ◯ Yes ◯ No Do your jaws ever feel tired? ◯ Yes ◯ No

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? ◯ Yes ◯ No Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = Awesome): _____

Would you like to have whiter teeth? ◯ Yes ◯ No

If you had a magic wand, what, if anything, would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight using Dental Imaging and Digital Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? ◯ Yes ◯ No **If yes, please select all that apply:**

☐ Lighten all front teeth showing	☐ Rebuild fracture(s)	☐ Straighten rotation	☐ Eliminate dark or stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

Please add anything you feel is important:

At Stunning Smiles of Las Vegas, though our focus is on appearance-related dentistry, our team also delivers routine general dental care as well. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results.

Thank you so much for the opportunity to be of service.

Warm Regards,
Richard A. Racanelli, DMD

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Please Handle Me With Care

_____
Patient Name

We feel it is necessary to develop a rapport with our patients. Many new patients have had a past unpleasant dental experience. It is crucial to us to know and understand your concerns. We are committed to taking the time to get to know you, discuss your concerns, your fears, and your dental expectations.

Please place a check mark in the box next to the statement that concerns you or describes your problem.

- ☐ I gag easily.
- ☐ I feel out of control when I'm lying down for a long time, and I feel uncomfortable about what you will say about my teeth and hygiene.
- ☐ Pain relief is a top priority for me.
- ☐ I don't like shots (or I've had a bad reaction to shots).
- ☐ Please tell me what I need to know about my mouth in order to make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.
- ☐ I am interested in oral sedation: for adults who need a deeper state of sedation

Partnership Pact:

I ask that you honestly inform me of all my dental problems. I want you to make me aware of the best quality dentistry available today. Then we can discuss how I can make healthy choices that will work within my budget. I also want to know all the pain relief options available to me, how each dental procedure will work, and how much of my time will be required.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Full Name: _____ Telephone: _____ Social Security#: _____

Address: _____ City: _____ State: _____ Zip: _____

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. 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 our office at (702) 736-0016 or by mailing us at 6410 Medical Center St., Ste. B, Las Vegas, NV 89148.

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 address above. Please understand that revocation of this Consent will not affect any action we took 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 healthcare 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:** _____

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

STUNNINGSMILES
Custom Smiles & Healthy Mouths

6410 Medical Center Street
Suite B
Las Vegas, NV 89148
P: 702.736.0016
W: www.lvstunningsmiles.com

Notice of Privacy Practices

You are entitled to receive our **Notice of Privacy Practices** upon request. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Included in the notice are:

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Your Choices

For certain health information, you can tell us your choices about what we share.

Other Uses and Disclosures

This section describes how we typically use or share your health information.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. This section describes all of our responsibilities in protecting your information.

To Request a Copy

We will provide a copy of our **Notice of Privacy Practices** to you upon request. Use the options below to indicate your preference:

I have been offered a copy of the *Stunning Smiles of Las Vegas* **Notice of Privacy Practices**.

I **DO / DO NOT** (circle an option) request a copy of the notice.

Your Name (Print) Your Signature Date

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Appointment Agreement

APPOINTMENT AGREEMENT

At Stunning Smiles of Las Vegas, we understand that your time is valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide courtesy reminders and confirmation text messages at 30, 14, 7 & 3 days. Once you have confirmed your appointment with us, you will no longer receive the courtesy texts, EXCEPT for the same-day 2 hour reminder text about your upcoming appointment time.

In the event you do need to change your reserved time with our office, would you please give us 48 hrs notice so that we can offer your appointment time to another patient? We appreciate your cooporation.

Signature of Patient or Responsible Party **Date**

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Office & Financial Policy

FINANCIAL POLICY

Please read carefully and sign to acknowledge understanding and agreement.

Thank you for choosing us as your dental care provider! We are committed to providing you with the best dental care available. Below we have outlined several payment options to help you get the dental treatment you may need, want and deserve.

Available Payment Options:

You can choose from ~ **Cash, Check, Visa, Mastercard, American Express**

We offer a 5% prepayment bookkeeping courtesy for to patients who pay for their treatment in full, at the time of scheduling.

Financing is available, ask us for details.

Dental Insurance:

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement on your behalf.

Your insurance is a contract between you and your insurance company. Stunning Smiles of Las Vegas is not part of that contract.

Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select services they will and will not cover.

If your insurance carrier does not pay the estimated benefit in full, you will be immediately responsible for any remaining balance. This balance may include any deductibles, co payments, denials and non covered services.

If we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees to our office and collection of your benefits directly from your insurance carrier.

Dental Benefits / Insurance:

* We will attempt to verify your benefit plan and give you as close of an estimate as we can for your treatment. Please understand that we don't know exactly how much your dental benfits will pay until the claim comes back. We do our best to give you an accurate estimate.

*We will try to answer any questions we can about your dental benefit plan and, when possible we will assist in resolving any issues with claims. Please understand that we cannot speak on their behalf. Your insurance contract is an agreement between you, your employer and your insurance carrier. In the event that your dental benefit company has not paid for your treatment, you will be responsible to pay your account.

Scheduling:

We do collect your *estimated* patient portion or in order to reserve time in Dr. Racanelli's schedule, or for an appointment time with our hygienist longer than 1 hour (except for new patient appts.). This allows us to provide the highest level of care to our patients. Should you have a residual balance after your insurance claim is closed, we will reach out to you to let you know.

Collections on Balances due:

A charge will be added to your account for any returned checks.

If you are experiencing financial difficulties in paying your balance, please reach out to use and we are happy to work with you to bring your account current.

Should your account be sent to collections, you are responsible to pay all costs of collecting, or attempting to collect any debt owed on this account. This includes all attorneys fees, interest, and late fees.

Responsible Party:

As the responsible party, in the case where my spouse and/or children are also patients at Stunning Smiles of Las Vegas, signing this Office & Financial Policies will apply to them and their accounts as well.

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Photos & Images

PHOTOS, IMAGES, X-RAYS

We take photos, of mouth, teeth, gums and smile as well as x-rays as part of our records. We sometimes also take intra-oral photos for documentation as well as for insurance claims.

I acknowledge and authorize Stunning Smiles of Las Vegas to take photographs, video and x-rays of my face, jaw, teeth and smile as a record of my care.

Occassionally we use patient case photos for social media and in our website gallery. Please select from multiple choice question if you agree to have your full face before and afters shown, or just images of your teeth/smile before and afters shown.

By signing this, you agree that your picture(s) can be shown publicly and you do not expect compensation, financial or otherwise for the use of these photographs.

Images/Photos (please select one of the following):

- ○ I agree to show my full face before and afters on website and social media
- ○ I agree to show ONLY my teeth/smile before and afters on the website and social media
- ○ I don't agree to any of my images shown in a non-clinical matter

SIGNATURE

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Phone #: _____ Today's date: _____

I authorize the professional office of my dentist, named above, to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released (names or classes of recipients):

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

Other persons that my information may be shared with:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

<u>It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose to not sign this authorization.</u>

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us your authorization is revoked. Send this note to the office contact listed above.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date: _____
Parent/Guardian: _____
Relationship to patient: _____