



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 unequalled 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](http://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



**REGISTRATION AND HEALTH HISTORY**

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_  male  female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
(Enter as MMDDYYYY)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
(Do NOT include dashes or spaces)

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: \_\_\_\_\_  
(Do NOT include dashes or spaces) (Enter as MMDDYYYY)

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:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N - Rheumatic Fever                | <input type="checkbox"/> Y <input type="checkbox"/> N - Thyroid Disease  | <input type="checkbox"/> Y <input type="checkbox"/> N - Seizure Disorder  |
| <input type="checkbox"/> Y <input type="checkbox"/> N - Heart Disease                  | <input type="checkbox"/> Y <input type="checkbox"/> N - Anemia   | <input type="checkbox"/> Y <input type="checkbox"/> N - Kidney Disease    |
| <input type="checkbox"/> Y <input type="checkbox"/> N - Heart Murmur (or MVP)          | <input type="checkbox"/> Y <input type="checkbox"/> N - Asthma   | <input type="checkbox"/> Y <input type="checkbox"/> N - Venereal Disease  |
| <input type="checkbox"/> Y <input type="checkbox"/> N - High Blood Pressure            | <input type="checkbox"/> Y <input type="checkbox"/> N - Diabetes   | <input type="checkbox"/> Y <input type="checkbox"/> N - Bleeding Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N - Tuberculosis                   | <input type="checkbox"/> Y <input type="checkbox"/> N - Are you nursing  | <input type="checkbox"/> Y <input type="checkbox"/> N - Cancer            |
| <input type="checkbox"/> Y <input type="checkbox"/> N - Use Oral Contraceptives        | <input type="checkbox"/> Y <input type="checkbox"/> N - Might you be pregnant  | <input type="checkbox"/> Y <input type="checkbox"/> N - Aids/HIV          |
| <input type="checkbox"/> Y <input type="checkbox"/> N - Artificial Joint / Heart Valve | <input type="checkbox"/> Y <input type="checkbox"/> N - Hepatitis Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Y <input type="checkbox"/> N - Eating Disorders  |
| <input type="checkbox"/> Y <input type="checkbox"/> N - History of Endocarditis        | <input type="checkbox"/> Y <input type="checkbox"/> N - Radiation Therapy: Head / Neck   | <input type="checkbox"/> Y <input type="checkbox"/> 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.



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 \_\_\_\_\_ How often do you floss? \_\_\_\_\_ time(s) a \_\_\_\_\_

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**



**SECTION A: PATIENT GIVING CONSENT**

Full Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
(Do NOT include dashes or spaces)

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.**

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. For your convenience we offer a wide range of financial options in order to pay for your dental treatment:

**A) Split Payment**

Half of the total treatment is due at the preparation visit, and the second half is due the day of cementation of the crowns/bridges/veneers.

**B) Pay as You Go**

You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

**C) Prepayment in Full**

For any treatment over \$2000, a prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

**D) CareCredit**

Care Credit offers No Interest financing for up to 24 months and low monthly payment options. There are no up front costs, no prepayment penalties and no fees as long as it is paid in full by the end of the term. This allows you to get the necessary work done now and pay later.

**FORMS OF PAYMENT ON BALANCES DUE**

In order to facilitate access to the very best dental care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Personal Checks or Care Credit (see above).

Interest of 1.5% per month will be charged on any unpaid balance after 60 days. This allows sufficient time for your insurance carrier to make payment. By law, insurance companies are required to make payment or deny a claim within 30 days. I understand that if I become delinquent on my account, my account will be turned over to a collection agency and I will subsequently be reported to the credit bureaus. In case of total default I agree to pay all costs for collection including but not limited to interest, court costs, sheriff fees, attorney fees and collection costs that may be incurred to collect on this account.

Please be aware that any parent or guardian bringing a child to our office is legally responsible for the payment of service rendered.

After your dental insurance has paid for dental services rendered at Stunning Smiles of Las Vegas, you may have an outstanding balance. This balance may include any deductibles, co-payments, denials, and non covered services. We do our best to estimate what you will owe. However, you are responsible (not your insurance company) for all fees for services rendered. For any balance owed, we require a credit card authorization

Credit Card: (check one):  Visa  MasterCard  Discover  Amex  CareCredit

Card#: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ CVV #: \_\_\_\_\_  
(Do NOT include dashes or spaces) (Enter as MMY)

Card Holder Signature: \_\_\_\_\_

Billing Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I certify that I have read, fully understand, and accept the above financial policy.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

- Patients find that if they take an analgesic prior to treatment it helps later in the day.  
 Which would you prefer?  Tylenol  Advil  Other: \_\_\_\_\_

- We provide various levels of sedation to ease your mind.  
 Would you benefit from a sedative?.....  Yes  No

If yes, we provide:  Mild sedative (oral medication  
 (Note: With mild sedative, you will need someone to drive you to the appointment.)

- Our treatment rooms are equipped with cable TV. Watching TV or a movie is an excellent way to pass the time during your visit. Please let us know what your favorite movie or TV shows are, and at your next appointment we will make sure we have it for you to watch.

- Complimentary WiFi Internet access is available for your use throughout the office. Please feel free to bring your wireless Internet device with you for each visit.

- Blankets help keep you warm and relaxed through your visit.  
 Would you like a blanket?.....  Yes  No

- Pillows provide an extra measure of comfort if you have a sore back or neck.  
 Would you like a pillow?.....  Yes  No

- Is there anything else we can do to make your visit comfortable?



## 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.



## APPOINTMENT AGREEMENT

At Stunning Smiles of Las Vegas, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. 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 reminder call and email 72 hrs prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 48 business hours so we are able to assist other patients with their dental needs. If our office is not notified within the 48 business hours, you will be subject to a \$50 late cancellation charge.

By signing below, I agree to fulfill my obligation as a patient at Stunning Smiles of Las Vegas and agree to the "broken appointment" fee should I not give proper notification.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date





## Completion Instructions

Thank you for taking the time to complete our New Patient Welcome Packet. If everything is correct, please print pages 2 - 8 and bring them in on your first appointment visit. Alternatively, you may submit this entire packet electronically to us by pressing the "**Submit via E-mail**" button below and following the on-screen instructions.

After successfully printing the document and verifying that everything is correct and fully complete (or after successful e-mail transmission), you may erase all form content by pressing the reset button below. Or, you may delete the entire file from your computer, if saved.

If you have questions regarding these instructions, please contact our office at (702) 736-0016.

Thank you,  
**Richard A. Racanelli, DMD**

**NOTE:** Before resetting this document, please make sure you have a correct and fully completed printed copy.  
*(Resetting document will permanently erase all entered data!)*