STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

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

STUNNINGSMILES OF LAS VEGAS
Excellence In Dentistry

REGISTRATION AND HEALTH HISTORY

Date: _____

First Name: _____ M.I. ____ Last Name: _____ ☐ male ☐ female Date of Birth: _____ (Enter as MMDDYYYY) Age: ____

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#: _____ (Do NOT include dashes or spaces) Insured's Date of Birth: _____ (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:

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

STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

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 select... How often do you floss? ____ time(s) a select...

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

STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

COMFORT MENU

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?

STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

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.

STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

NOTICE OF PRIVACY PRACTICES

Stunning Smiles of Las Vegas
Richard A. Racanelli, DMD
6410 Medical Center St. Ste. B, Las Vegas, NV 89148
702.736.0016
info@lvstunningsmiles.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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.

- Get an electronic or paper copy of your medical record
  - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
  - We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record
  - You can ask us to correct health information about you that you think is incorrect or incomplete.
  - Ask us how to do this.
  - We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- Request confidential communications
  - You can ask us to contact you in a specific way (such as home or office phone) or to send mail to a different address
    - We will say “yes” to reasonable requests
- Ask us to limit what we use or share
  - You can ask us not to use or share certain health information or treatment, payment or our operations.
    - We are not required to agree to your request, and we may say “no” if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
    - We will say “yes” unless a law requires us to share that information.
- Get a list of those with whom we’ve shared information
  - You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with and why.
  - We will include all the disclosures except for those about treatment; payment and heath care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice
  - You can ask for a paper copy of this privacy notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- Choose someone to act for you
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated
  - You can complain if you feel we have violated your rights by contacting us using the information at the top of page 1.
  - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave. S.W., Washington, D.C. 20201, calling 1-877-696-6775 or visiting: www.hhs.gov/ocr/privacy/hippa/complaints/.
  - We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- In these cases, you have both the right and choices to tell us to:
  - Share information with your family, close friends or others involved in your care
  - Share information in a disaster relief situation
  - Include your information in a hospital directory
  - Contact you for fundraising efforts
  - If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information when needed to lesson a serious and imminent threat to your health or safety.
- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
- In the case of the fundraising:
  - We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- Treat you
  - We can use your health information and share with other professionals who are treating you.
    - Example: A doctor treating you for an injury asks another doctor about your overall health condition
- Run our organization
  - We can use and share your health information to run our practice, improve your care, and contact you when necessary
    - Example: We use health information about you to manage your treatment and services

- Bill you for services
  - We can use and share your health information to bill and get payment from health plans or other entities
    - Exampe: We give information about you to your health insurance plan so it will pay for your services

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. WE have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hippa/understanding/consumers/index.html

- Help with public health safety issues
  - We can share health information about your for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- Do research
  - WE can use or share your information for health research
- Comply with the law
  - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donor requests
  - We can share health information about your organ procurement organizations
- Work with a medical examiner or funeral director
  - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests
  - We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government function such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions
  - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gove/ocr/privacyhippa/understanding/consumers/noticeapp.html

STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

Changes to the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Stunning Smiles of Las Vegas's Notice of Privacy Practices.

Patient Name (Please Print)	**Patient, Parent or Guardian Signature**	**Date**

STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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.

STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

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**

STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

OFFICES POLICIES

Appointments & Deposits:

- At Stunning Smiles of Las Vegas we consider the appointment the confirmation. Although we may send you reminders, by setting the appointment we are making a commitment to block a portion of time specifically for you and making it unavailable for other patients.
- As a courtesy, please notify Stunning Smiles of Las Vegas if you cannot make your appointment at least 48 hours prior to the scheduled time. Missed or late cancelled appointment may be subject to a fee of $50 per hour scheduled.
- For patients with a history of missing or cancelling appointments at the last minute, Stunning Smiles of Las Vegas reserves the right to double book your future appointments. Although we will try to keep the time open for you, we may schedule other patients to ensure that the time slot is filled and not wasted. Should your appointment be double-booked, we will treat the other patient first, which may result in your appointment needing to be rescheduled.
- For patients with a history of missing or cancelling appointments at the last minute, Stunning Smiles of Las Vegas may require a deposit to secure a future appointment.
- Appointments for treatment that require more than (1) hour will require a deposit of 50% of the patient portion to secure the appointment.

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.

Financial Policy:

- Forms of payment we accept:
  - Cash
  - Credit Cards (MasterCard, Discover, American Express, Visa and Care Credit)
  - In-house and 3rd party payment plans
  - Prepayment in Full (For any treatment over $2000, we offer a 5% Bookkeeping Courtesy for payment in full with cash or check before the first treatment visit.)
- If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

Payments & Collections:

- Patient acknowledges and agrees that all accounts past 60 days shall bear a compounding interest rate of 1.5% per month. In the event that patient does not pay for performed services and the account becomes delinquent, Stunning Smiles of Las Vegas may turn the account over to a collection agency. Patient further agrees to pay reasonable collection fees, attorney fees and court costs incurred in collection of an overdue account.

Photos & Images:

- I authorize Stunning Smiles of Las Vegas to take photographs, x-rays, and or videos of my face, jaws and teeth as a record of my care.
- I authorize Stunning Smiles of Las Vegas to use photos of a non-clinical nature for their website or social media with the following exceptions:
  - I do not wish to have my first name shown or released
  - I do not wish to have my entire face shown
  - I only agree to have my teeth shown without any identifying features.
- I do not expect compensation, financial or otherwise for the use of these photographs.

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 Policies from will apply to them and their accounts as well.

_____ _____

Signature of Responsible Party/Cardholder **Date**

_____ _____

Print Name of Responsible Party/Cardholder **Date**

STUNNINGSMILES
OF LAS VEGAS
Excellence In Dentistry

Completion Instructions

Thank you for taking the time to complete our New Patient Welcome Packet. If everything is correct, please print pages 2-13 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

Print Form

Submit via E-mail

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!)

Reset Form