TIME 09:14 AM

DATE 6/9/2016

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Who referred you?

Current PCP?

Personal Motivator?

Former Dental Office

AM or PM APPTs?

Dental Fears?

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Dovetail Dental
ASSOCIATES

Please sign below after you read and understand our programs and policies

Referrals

For every new patient you refer to Dovetail, you will receive a $25 account credit to be used in our office. The credit will be applied to your account when the new patient has completed this form *with your name written in the referral source section.*

Who may we thank for inviting you?

- ☐ Current patient: _____
- ☐ Through my dental insurance
- ☐ On the internet
  - ☐ Google
  - ☐ Yahoo
  - ☐ Bing
  - ☐ Yelp
  - ☐ Facebook
  - ☐ Healthprofs.com
  - ☐ Healthgrades.com
  - ☐ Other (please specify): _____

Financial Policy

Compensation for services is due when treatment is performed. Payment options include: cash check, credit card, or third party financing through CareCredit or Lending Club Payment Solutions. We want to help you achieve your goals, so if you would like to discuss your payment options, please speak with Melinda, our Treatment Coordinator.

Missed Opportunity Policy

We are dedicated to giving you the best care possible. If you are unable to keep your appointment, please give us at least 24 hours notice so someone else may have the opportunity to use the time we have reserved for you. If you cancel last minute, or do not come to a scheduled appointment time due to a non-emergency, we will charge you $50 for a missed opportunity with the doctor and/or $30 for a missed opportunity with your dental hygienist. Thank you in advance for your cooperation in ensuring a smooth-running schedule.

Patient Signature: _____ Date: _____

Acknowledgement of Receipt
Notice of Privacy Practices

Dovetail Dental ASSOCIATES

Consent to Share Information

I, (print name) _____, give permission to share information regarding my treatment and/or finances to (check all that apply):

- ☐ Parent Name: _____
- ☐ Spouse Name: _____
- ☐ Guardian Name: _____
- ☐ Other: _____

I also give permission for messages to be left on my home, work, or personal voicemail for confirmation of appointments or to communicate insurance or account information.

_____ _____

Patient Signature Date

HIPAA Privacy Notice

I, (print name) _____, have read and understand the notice of privacy practices at Dovetail Dental Associates and acknowledge I may request a copy of the document at any time.

_____ _____

Patient Signature Date

*You may refuse to sign this acknowledgement

Office Use Only

Acknowledgement could not be obtained due to:

___ Refusal to sign
___ Communication barriers prohibited informed consent
___ An emergency situation prevented our ability to obtain acknowledgement
___ Other: _____

Office Team Member: _____ Date: _____

Dovetail Dental
ASSOCIATES

282 Route 101
5 Liberty Park
Amherst, NH 03031
Phone: 603-673-6526
Fax: 603-673-0417
toothmail@dovetaildental.com

Date:

Dear Dr.

Please forward all records for _____ to:

Dovetail Dental Associates
Joseph Cariello, DDS
282 Route 101,5 Liberty Park
Amherst, NH 03031
toothmail@dovetaildental.com

This request also applies to the following patient (s):

_____ D/O/B _____

_____ D/O/B _____

_____ D/O/B _____

Please consider this signed form as an official release.
Your prompt attention to this request is appreciated.

Signature of patient or guardian: _____

Printed name of patient or guardian: _____

Time 11:18 AM | Joseph Cariello D.D.S., P.C. | Date 5/6/2016

Dovetail's Comprehensive Medical History 2016

Patient Name: Birth Date: Date Created:

Although our team primarily treats the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you allergic to any of the following?

☐ Acrylic	☐ Gluten	☐ Local Anesthetics	☐ Penicillin
☐ Aspirin	☐ Iodine	☐ Metal	☐ Sulfa Drugs
☐ Codeine	☐ Latex		

Do you have any other allergies? If so, please list them:	○ Yes ○ No	If yes
Do you have a Primary Care Physician?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Are you taking any medications,supplements, vitamins, or drugs? If so, what do you take?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Have you ever had pregnancy complications?	○ Yes ○ No	If yes

Do you have, or have you had, any of the following?

Acid Reflux	○ Yes ○ No	Convulsions	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Pre Eclampsia	○ Yes ○ No
AIDS/HIV Positive	○ Yes ○ No	COPD	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Herpes	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Diabetes	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Recent Extreme Weight Loss	○ Yes ○ No
Anemia	○ Yes ○ No	Difficulty Sleeping	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Angina/Chest Pain	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Anxiety	○ Yes ○ No	Easily Winded	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arrhythmia	○ Yes ○ No	Emphysema	○ Yes ○ No	Inflammatory Disease	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Arthritis	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Irritable Bowel Syndrome	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Jaundice	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Asthma	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Disease	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Autism Spectrum Disorder	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Kidney Stones	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Autoimmune Disorder	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Leukemia	○ Yes ○ No	Stroke	○ Yes ○ No
Blood Disease	○ Yes ○ No	Glaucoma	○ Yes ○ No	Liver Disease	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Blood Thinners	○ Yes ○ No	Gout	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Hay Fever	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Breathing problems	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Lyme Disease	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Migraines	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Cancer	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Ulcers	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Vascular Dysfunction	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Hemophilia	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No						

Have you ever had any serious illness not listed	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you under stress?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes

Oral Health

Do you have, or have you had, any of the following?

A Difficult Dental Experience	○ Yes ○ No	Difficulty Swallowing	○ Yes ○ No	Excessive Thirst	○ Yes ○ No
Bad Breath	○ Yes ○ No	Dry Mouth	○ Yes ○ No	Neck or Jaw Pain/discomfort	○ Yes ○ No

Do you think you have a healthy mouth?	○ Yes ○ No	
Have you been diagnosed with Periodontal Disease?	○ Yes ○ No	
Would you change anything about your smile? If so, what would you want to change?	○ Yes ○ No	If yes

Family History

Has anyone in your immediate family been diagnosed with any of the following? If so, which family member?

Alzheimer's Disease	○ Yes ○ No	If yes
Cancer	○ Yes ○ No	If yes
Diabetes	○ Yes ○ No	If yes
Heart Attack/Failure	○ Yes ○ No	If yes
Periodontal Disease	○ Yes ○ No	If yes
Thyroid Problems/Disease	○ Yes ○ No	If yes

Comments:

Emergency Contact name and phone number:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____