Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

KRIS SOTTOSANTI, DDS• 26535 CARMEL RANCHO BLVD SUITE 1• CARMEL, CA 93923• (831) 624-8548

PATIENT INFORMATION

Name _____ ◯ Dr. ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Rev. ◯ Other: _____
First MI Last

Address _____ Occupation: _____ ◯ Male ◯ Female

City _____ State _____ Zip _____ Hm# (___)_____

Employer _____ Wk# (___)_____ Ext _____

Are you: ◯ Minor ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated Cell # (___)_____

DOB: ___/___/_____ SSN# _____ E-mail _____@_____

Spouse's Name _____
First MI Last (if different)

Spouse occupation _____ Work phone _____ Ext _____

Is patient a full time student? ◯ No ◯ Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Hm# (___)_____

Wk# (___)_____

DOB: ___/___/_____

SSN# _____

Relationship: _____

About Dr. Sottosanti:
Doctor of Dental Surgery, University of the Pacific San Francisco
Certified Advanced CEREC
Member:
California Dental Association
American Academy of Cosmetic Dentistry
Alumni :
Pacific Aesthetic Continuum

YOUR PREFERENCES

Do you prefer appointment reminders by: ◯ Email ◯ Phone ◯ Text
Do you prefer to receive calls from our office at: ◯ Home ◯ Work ◯ Cell
Whom may we thank for referring you? How do you wish to be addressed by our staff?

_____ _____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____

DOB: ___/___/_____ Subscriber's SSN# _____

Insurance Company _____ Policy # _____ Group # _____

DENTAL INSURANCE:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ___/___/_____ SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/___

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ◯ Yes ◯ No If yes, please complete the following:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ___/___/_____ SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/___

Our practice is one of the most advanced CAD/CAM practices in the US. We use 3-D CEREC technology to produce ceramic restorations in a single visit.

CONFIDENTIAL

"We are dedicated to helping you achieve optimum oral health and a beautiful smile for a lifetime."
The Team at Kris Sottosanti, DDS

MEDICAL HISTORY and CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies

Acrylics	Y ◯ N ◯
Anaphalaxis	Y ◯ N ◯
Latex	Y ◯ N ◯
Local Anesthetics	Y ◯ N ◯
Penicillin	Y ◯ N ◯
Metal	Y ◯ N ◯
Sulpha	Y ◯ N ◯
Other	Y ◯ N ◯

List other known allergies:

_____

_____

_____

_____

_____

Cardiovascular

Artificial Heart Valve	Y ◯ N ◯
Coronary Artery Disease	Y ◯ N ◯
Chest Pain or Angina	Y ◯ N ◯
Congestive Heart Failure	Y ◯ N ◯
Heart Attack	Y ◯ N ◯
Heart Murmur	Y ◯ N ◯
High Blood Pressure	Y ◯ N ◯
High Cholesterol	Y ◯ N ◯
Irregular Heart Beat	Y ◯ N ◯
Low Blood Pressure	Y ◯ N ◯
Mitral Valve Prolapse	Y ◯ N ◯
Pacemaker	Y ◯ N ◯
Tachycardia	Y ◯ N ◯

Endocrine

Diabetes	Y ◯ N ◯
Gout	Y ◯ N ◯
Hormonal Change	Y ◯ N ◯
Thyroid problems	Y ◯ N ◯

Eyes, Ears, Nose and Throat

Change in Hearing	Y ◯ N ◯
Change in Vision	Y ◯ N ◯
Dysphagia	Y ◯ N ◯
Ear Pain	Y ◯ N ◯
Glaucoma	Y ◯ N ◯
Hay Fever	Y ◯ N ◯
Nasal Obstruction	Y ◯ N ◯
Nose Bleeding	Y ◯ N ◯
Sinus Problems	Y ◯ N ◯
Tonsillectomy	Y ◯ N ◯
Tinnitus	Y ◯ N ◯

Gastrointestinal

Acid Reflux	Y ◯ N ◯
GERD	Y ◯ N ◯
Soft or Special Diet	Y ◯ N ◯
Ulcers	Y ◯ N ◯

Genitourinary

Frequent Urination	Y ◯ N ◯
Kidney disease	Y ◯ N ◯
Nocturia	Y ◯ N ◯

General

Current weight: _____lbs

Height: _____ ft _____in

Cancer	Y ◯ N ◯
Fatigue/Tired	Y ◯ N ◯
General Weakness	Y ◯ N ◯
Headaches	Y ◯ N ◯
HIV/AIDS	Y ◯ N ◯
Knee/hip replacement	Y ◯ N ◯
Liver problems	Y ◯ N ◯
Recent Trauma or Injury	Y ◯ N ◯
Rheumatic Fever	Y ◯ N ◯
Radiation Treatment	Y ◯ N ◯
Weight Change	Y ◯ N ◯

Hematological

Bleeding problems	Y ◯ N ◯
Hepatitis	Y ◯ N ◯

Oral

Bleeding gums	Y ◯ N ◯
Dry mouth	Y ◯ N ◯
Jaw problems (TMJ)?	Y ◯ N ◯
Clicking?	Y ◯ N ◯
Pain?	Y ◯ N ◯
Difficulty swallowing?	Y ◯ N ◯
Difficulty chewing?	Y ◯ N ◯
Orthodontics/Invisalign	Y ◯ N ◯
Periodontal Disease	Y ◯ N ◯
Teeth clenching	Y ◯ N ◯
Teeth grinding	Y ◯ N ◯
Tooth pain	Y ◯ N ◯
Wisdom teeth extraction	Y ◯ N ◯
Do you wear removable teeth?	Y ◯ N ◯
Do you take or need antibiotics before dental procedures?	Y ◯ N ◯

Musculoskeletal

Back Pain	Y ◯ N ◯
Fibromyalgia	Y ◯ N ◯
Joint Pain	Y ◯ N ◯

Neurological

Alzheimer's Disease	Y ◯ N ◯
Dizziness	Y ◯ N ◯
Fainting	Y ◯ N ◯
Memory Loss	Y ◯ N ◯
Multiple Sclerosis (MS)	Y ◯ N ◯
Muscle Weakness	Y ◯ N ◯
Seizures	Y ◯ N ◯
Stroke	Y ◯ N ◯
Tingling/Numbness	Y ◯ N ◯
Trigeminal Neuralgia	Y ◯ N ◯
Tremor	Y ◯ N ◯

Psychiatric

ADD/ADHD	Y ◯ N ◯
Anxiety	Y ◯ N ◯
Chemical Dependency	Y ◯ N ◯
Depression	Y ◯ N ◯
Eating disorders	Y ◯ N ◯
Excessive Stress	Y ◯ N ◯
Memory problems	Y ◯ N ◯

Respiratory

Asthma	Y ◯ N ◯
Bronchitis	Y ◯ N ◯
Breathing problems	Y ◯ N ◯
Chest Pressure	Y ◯ N ◯
Congestion	Y ◯ N ◯
Dyspnea(shortness of breath)	Y ◯ N ◯
Emphysema	Y ◯ N ◯
Orthopnea	Y ◯ N ◯
Pneumonia	Y ◯ N ◯
Pulmonary Embolism	Y ◯ N ◯
Tuberculosis	Y ◯ N ◯

Sleep

Daytime Sleepiness	Y ◯ N ◯
Morning headaches	Y ◯ N ◯
Obstructive Sleep Apnea	Y ◯ N ◯
Do you use a CPAP?	Y ◯ N ◯

How often? _____

Has anyone told you that you snore? Y ◯ N ◯

Social History

Do you smoke? Y ◯ N ◯

_____ packs a day

Do you use smokeless tobacco? ◯ Y N ◯

Do you consume alcoholic beverages?

_____Drinks per day/week/month

Do you use recreational drugs? ◯ Y N ◯

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Kris Sottosanti DDS

MEDICAL HISTORY and CONSENT

List any medications you are taking:

Medication	Dosage/Freq.	Prescriber	Reason
1.			
2.			
3.			
4.			
5.			
6.			

List any surgeries or hospitalizations you have had:

Date(year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above:

_____

_____

_____

_____

Primary Physician's Name: _____ Physician's phone #: _____

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Kris Sottosanti DDS, A Professional Corp, to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Kris Sottosanti DDS, A Professional Corp, to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Kris Sottosanti DDS, A Professional Corp, choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Kris Sottosanti DDS, A Professional Corp. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.
FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Kris Sottosanti DDS, A Professional Corp, and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult):

Name of Patient _____ _____ Date _____
Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian _____ _____ Date _____
Signature of Parent/Guardian

Notice of Privacy Practices (below)
Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ Date _____
Signature of Patient

Kris Sottosanti DDS

KRIS SOTTOSANTI, D.D.S.

TELEPHONE USAGE POLICY

Kris Sottosanti, D.D.S. ("Dr. Sottosanti") maintains a telephone system to assist in conducting patient care and related business. Dr. Sottosanti's telephone system includes the ability to record and store all conversations conducted using Dr. Sottosanti's telephone system. Telephone conversations conducted using Dr. Sottosanti's telephone system may be recorded. Dr. Sottosanti's telephone system, including but not limited to all equipment and recorded conversations and messages, is and at all times remains the property of Dr. Sottosanti.

Dr. Sottosanti's use of its telephone system, including recorded conversations and messages, will comply with Dr. Sottosanti's policies relating to patient privacy, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and confidential and proprietary information.

PATIENT ACKNOWLEDGEMENT AND CONSENT

Patient Name: _____

I acknowledge that I have received a copy of Dr. Sottosanti's Telephone Policy. I further acknowledge and understand that Dr. Sottosanti may record any and all telephone conversations using Dr. Sottosanti's telephone system and hereby consent to such recording by Dr. Sottosanti.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date