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*Creating smiles and changing lives!*

*Welcome!*

*I am delighted that you have chosen me to attend to your dental care needs. At Enchanted Smiles I combine the cutting edge techniques of modern dentistry with state-of-the-art technology to help you obtain your ideal functional and esthetic dental health. My practice is built on a solid foundation of excellence in dentistry; I am the only dentist in Topeka to have attained advanced training and Fellowship status at the internationally renowned Las Vegas Institute for Advanced Dental Studies. I am excited to use these advances to the benefit of my patients in the Midwest.*

*I believe that the best dental care begins with a friendly and mutual understanding between dentist and patient regarding your ultimate treatment goals and the necessary steps to attain them. My approach to dentistry is designed with the flexibility to allow you to achieve your "ultimate" goals at a pace you can control, while guaranteeing a fresh look and great smile at each step of the way.*

*I provide the following dental services:*

- Smile makeover*
- Porcelain veneers*
- Cosmetic dentistry*
- Full Mouth Restoration*
- General Dentistry*
- Crowns*
- Root Canal*
- Whitening*
- Chipped or fractured tooth repair*

*I also provide treatment for:*

- Sleep Apnea*
- Temporo Mandibular Joint (TMJ) pain*
- Headache*
- Neck and Shoulder pain*
- Vertigo*

*By filling out the enclosed questionnaire, you can help us determine your dental needs and concerns. Ultimately, whatever treatment you receive is completely your choice. For whatever treatment you select, we'll help you understand your insurance coverage. In today's world many aesthetic dental services are considered out-of-pocket expenses; nevertheless, we also provide options for financing your treatment, if needed.*

*We highly recommend that you complete the following paperwork and mail it, or fax it to us at (785) 246-6302, at last two days prior to your dental visit. By helping us prepare for your visit, we can ensure you have the best possible experience!*

*Thank you for choosing my practice.*

*Dr. Stefania Caracioni and the Enchanted Smiles Team*



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**Personal Information**

Mr. Mrs. Miss \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Phone (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_  
Emergency Contact:  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_  
Parent/Guardian/Person Financially Responsible (if applicable):  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_  
Family Physician's Name \_\_\_\_\_ Phone (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

How did you hear about us?

*We do appreciate referrals. Please let us know the name of the person who recommended you so we can show our gratitude.*

Family member, friend, associate \_\_\_\_\_  
Doctor \_\_\_\_\_ Internet search \_\_\_\_\_ Phone book \_\_\_\_\_ Flyer \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Other, please specify \_\_\_\_\_  
What do you know about our office and what expectations do you have? \_\_\_\_\_

**Health and Dental History**

Do you have a history of (circle which one):  
rheumatic fever, heart murmur, artificial valve or joint replacement which now requires premedication?  
Are you taking any medication now, including aspirin?  
No Yes, Please list \_\_\_\_\_  
Have you been under the care of a medical doctor during the past two years?  
No Yes, If so, for what \_\_\_\_\_  
Are you aware of having an allergic reaction to any medication or substance?  
No Yes, Please List \_\_\_\_\_  
Is there any other health related information that you think we must be aware of?  
\_\_\_\_\_

Do you currently have any dental pain?  
No Yes, If yes, where \_\_\_\_\_  
If yes to the above, is the pain: \_\_\_\_\_ sporadic \_\_\_\_\_ constant \_\_\_\_\_ dull \_\_\_\_\_ sharp \_\_\_\_\_  
Do you have any other current dental concerns/comments? \_\_\_\_\_  
In your opinion, tell us what you think the present state of the health of your mouth is?  
\_\_\_\_\_

When was your last dental visit?  
less than a month ago 1-3 months ago 4-6 months ago 7-12 months ago Over a year ago  
How do you feel about the appearance of your smile? \_\_\_\_\_  
Is time a factor in getting your dental work done? Yes No  
Has fear ever been an issue for you in a dental office? Yes No  
Is there any additional information that you would like to provide regarding your dental treatment?  
\_\_\_\_\_



# Enchanted Smiles

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Indicate which of the following you have had, or have at present. Please circle yes or no to each item.

Heart Disease	Yes	No	Headaches	Yes	No
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No
Heart Murmur	Yes	No	Jaw Popping	Yes	No
Mitral Valve Prolapse	Yes	No	Congested Ears	Yes	No
Artificial Heart Valve	Yes	No	Limited Jaw Opening	Yes	No
Pacemaker	Yes	No	Ringling in the Ears	Yes	No
High Blood Pressure	Yes	No	Dizziness	Yes	No
Stroke	Yes	No	Grinding	Yes	No
Liver Disease/Jaundice	Yes	No	Clenching	Yes	No
Artificial Joints	Yes	No	Loose Teeth	Yes	No
Kidney Disease	Yes	No	Difficulty Chewing	Yes	No
Diabetes	Yes	No	Difficulty Swallowing	Yes	No
Hepatitis	Yes	No	Facial Pain	Yes	No
Neurological Disorders	Yes	No	Sensitive Teeth	Yes	No
Radiation/Chemotherapy	Yes	No	Neck Ache	Yes	No
Epilepsy/Seizures	Yes	No	Bell's Palsy	Yes	No
AIDS/HIV	Yes	No	Trigeminal Neuralgia	Yes	No
Psychiatric/Psychological	Yes	No	Tingling in Arms/ Fingers	Yes	No
Latex Sensitivity	Yes	No	Insomnia/ Frequent Waking	Yes	No

Do you have or have you had any disease, condition, or problem not listed? \_\_\_\_\_

Do you smoke or chew tobacco? Yes No

Does floss shred when you use it? Yes No

Does food pack or catch between your teeth? Yes No

Women:

Are you pregnant? Yes No Are you nursing? Yes No Are you taking birth control pills? Yes No

**Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.**

*I authorize the staff to perform any necessary services during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information is necessary to provide me with dental care in a safe and efficient manner.*

*I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you.*

*I will notify the doctor of any change in my health or medication.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_



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### **Insurance information**

As a courtesy to you, we will file and submit all insurance claims on your behalf. The estimated co-payment (uninsured portion of your dental service) is due at the time of service.  
For more advanced procedures, or at your request, we will obtain preauthorization from your insurance provider.

Dental Insurance Company \_\_\_\_\_  
Insurance Company Phone Number \_\_\_\_\_  
Employer \_\_\_\_\_  
Member ID Number \_\_\_\_\_  
Group Number \_\_\_\_\_  
Subscriber Date of Birth \_\_\_\_\_

Policy Holder Information: (This is the main person on the plan, ex. Spouse or Parent)

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Relation to Patient \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_\_\_

### **Appointment cancellation policy**

*If you are ever unable to make an appointment you have scheduled with us, please notify us at least 24 hours in advance. We would be glad to reschedule the appointment at a more convenient time, if necessary. If however an appointment is missed and/or cancelled without a 24-hour notice, we reserve the right to charge you a \$30.00 fee.*

*I have read and understood the cancellation policy.*

Patient Signature \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_\_\_