L A M E N D O L A D E N T I S T R Y

Please Print

Chart Number _____

Patient's Name: Circle one: Dr/Mr/Mrs/Ms/Miss

First: _____ Middle: _____ Last:_____ Jr/Sr:_____

Address: _____ City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email Address:_____

Patient Social Security Number: _____ Date of Birth: _____

Sex: (circle) **M F** Status: (circle) **Single Married**

Responsible Party: _____ Phone: _____ Relation: _____

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about Lamendola Dentistry? **(Please Circle One)**

Yellow Pages Sunshine Pages Pelican Pages Facebook Sign
Magazine:_____ Internet Billboard Other:_____

Internet: <u>if so, please circle which search engine:</u> Google MSN Bing Yahoo LocateADoc

What word did you search for? _____ What day did you search? _____

Insurance Information

Do you have Dental Insurance? (circle) **Yes No** Do you have secondary Dental Insurance? (circle) **Yes No**

Primary Insured	Secondary Insured
Subscriber Name	Subscriber Name
Subscriber SSN	Subscriber SSN
Date of Birth	Date of Birth
Relationship to Subscriber	Relationship to Subscriber
Self Spouse Child Other	Self Spouse Child Other
Employer Name	Employer Name
Employer Phone	Employer Phone
Insurance Company	Insurance Company
Insurance Group #	Insurance Group #
Insurance Phone #	Insurance Phone #

Please present card to receptionist to be photocopied

Health Information

Patient's Name:_____ Date of Birth: _____

Physician's Name & Phone #:_____

Reason for today's visit? _____

Date of last dental visit? _____ Date of last dental x-rays:_____

Why did you leave your last dentist? _____ If wearing dentures, age of dentures: _____

What treatment would you like to have completed? _____

Have you ever had any of the following dental treatment:	**Y**	**N**		**Y**	**N**		**Y**	**N**
Extraction/Date _____			Crowns/Bridges			Cosmetic Whitening		
Root Canal/Endodontics			Partial Dentures			Veneers		
Fillings			Complete Dentures			Orthodontics		
Gum/Periodontal Surgery			Implants			Other _____		

For any existing crowns, bridges, partials, or dentures? How old? _____

I brush _____ times a day.

I floss _____ times a day.

How often do you visit the dentist? _____

Do you have a history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**
Epilepsy/Seizures/Date____			Psychiatric Disorder			Joint Replacement		

Chemical Dependency			Recurrent Bronchitis			Stomach/Intestinal Disease		
High Blood Pressure			Pneumonia			Skin Disorders		
Heart surgery/Date_____			Tuberculosis			Diabetes		
Heart Attack/Date_____			Hepatitis (type A, B, C)			Anemia/Hemophilia		
Stroke/Date_____			Kidney Failure			Venereal Disease		
Chest Pains/Angina			HIV/AIDS			Asthma		
Congenital Heart Disease			Kidney Stones			Cancer		
Thyroid			Osteoporosis			Mitral Valve Prolapse		
Other_____								

Are you ALLERGIC to:	**Y**	**N**		**Y**	**N**
Penicillin			Latex		
Aspirin			Sulfa		
Codeine			Other _____		

Do you smoke? _____ Packs per day? _____

Do you use alcoholic beverages? _____ Drinks per week?_____

LADIES ONLY: Are you pregnant? _____ If so, what month?_____

List all medications you are currently taking:

_____

Consent Forms

Consent for Dental Treatment and Acknowledgement of Receipt of Information

State law requires us to obtain your consent for the contemplated dental treatment. What you are being asked to sign is confirmation that we have discussed the nature and purpose of your contemplated treatment and the risks associated therewith. Ask about anything you do not understand. We will be pleased to explain.

I hereby authorize and direct **Lamendola Dentistry**, assistants, hygienists, and specialists of their choice to perform upon _____ the following dental procedures:

Photographs, radiographs, study models, extraction and other surgical procedures, biopsies, periodontal cleaning and/or surgery, fillings, root canals, partials and/or complete dentures, crowns, bridges, bleaching and tooth lightening procedures, porcelain and resin veneers, lumineers, and splints including any necessary or advisable anesthesia.

ALTERNATIVES TO THE RECOMMENDED DENTAL TREATMENT:

Alternatives to the recommended treatment, including no treatment, have been explained to me as have the advantages and disadvantages of each.

RISK ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT:

I understand that dentistry is not an exact science and that complications may occur despite our best efforts. A partial listing of the risks known to be associated with this treatment and with the associated anesthetic are:

Swelling and bruising, which may necessitate staying home for a few days. Bleeding sometimes prolonged enough to necessitate additional services to cause it to cease. Instrument breakage and/or retained instrument fragment(s). Breakage of roots and/or retained root fragments. Parasthesia – permanent or temporary numbness of the cheeks, gums, teeth, lips, tongue, chin, and face. Loss of taste, loss/damage to adjacent teeth and bone, fracture of the jaw, sinus involvement, change in the bite, TMJ Dysfunction or worsening of TMJ condition, Trismus (jaw pain or difficulty opening the mouth), swallowing/aspiration of objects, infection/dry socket, pain, drug/allergic reaction, stretching of the mouth, which may cause bruising or result in cracking. Failure of the treatment to accomplish its purpose, further surgery and/or treatment.

USE OF ILLICIT DRUGS:

The use of illicit or street drugs can adversely affect treatment, including anesthesia and sedation, possibly resulting in death. Please notify the doctor if you have used any drugs within the last 24 hours. State law also requires that I specifically advise you that, although rarely occurring, the dental treatment of anesthetic may result in death, brain damage, quadriplegia, paraplegia, loss of organ(s), loss of function of an organ(s), loss of

function of face, arm(s), or leg(s), and disfiguring scars.

PHOTOGRAPHS:

I hereby specifically authorize the above doctors and staff to take, develop and use photographs at all phases of my treatment for educational, demonstrative and/or promotional purposes specifically including use in lectures and publications and I do hereby forever waive any claim to royalties or other monies or other sources of reimbursement that are received from their use.

ACKOWLEDGEMENT

I acknowledge that I have read and I understand the information on both pages of this consent form (or that it has been read to me). I understand the information contained in it, including all of the technical terms, about which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I had about treatment. All of the questions about the treatment have been answered in a satisfactory manner.

I understand that the success of this treatment and the avoidance of treatment complications depend to an extent upon my complying with the oral hygiene and dietary restrictions that have been explained to me and my keeping appointments for treatment or follow-up office visits scheduled or recommended. I also understand that I am to notify the dentist immediately of any suspected complication(s), where further treatment may be discussed, or administered, which is not currently anticipated.

I hereby authorize **Lamendola Dentistry**, hygienists, specialists or assistants of their choice to perform diagnostic, surgical or dental treatments. This Consent Form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature. I waive further disclosures or information.

_____

Patient Name

_____

Signature of Patient/Guardian

_____

Signature of Doctor

_____

Date

Authorization for Dental Care on a Minor

I authorize dental treatment to be rendered on my child/minor, _____, without my physical presence in the dental office. I have been advised that it is ideal to have a parent/legal guardian present in the office during treatment in case of any complications or medical situations that may arise. With knowledge of this, I authorize Lamendola Dentistry to take any emergency care/action or precautions deemed necessary. I still retain the authority to approve or decline treatment to be rendered and will make that designation clear before the appointment either in person or by phone consent.

_____

Patient Name

_____

Signature of Parent/Guardian

_____

Signature of Doctor

_____

Date

Financial Arrangement Agreement

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

In order to be impartial to everyone, WE REQUIRE PAYMENT AT THE TIME OF THE TREATMENT. We ask that you read and sign this statement prior to any treatment. YOUR CO-PAY AND DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF THE TREATMENT. We accept cash, checks, Visa, MasterCard, Discover Card, and American Express. For extensive treatment plans, we offer extended payment plans with CareCredit at either little or no interest with prior credit approval.

ACKNOWLEDGEMENT

I hereby certify that the medical and dental history provided is correct to the best of my knowledge and give my consent for the doctors and staff at Lamendola Dentistry to treat my dental needs based on this information.

MISSED APPOINTMENTS

In order to be fair to all our patients, we ask that you notify our office at least 72 hours in advance if you cannot keep your scheduled appointment. Our policy for any missed appointments is a charge of a normal office visit.

REGARDING INSURANCE

We will gladly file all dental claims for a given treatment but we are not party to any insurance programs or contracts. The balance is YOUR responsibility whether your insurance company pays for your treatment or not. It is your responsibility to inform us of any changes in your insurance coverage.

I authorize Lamendola Dentistry to release any dental information necessary to process dental insurance claims. I also request and authorize payments of any benefits, applicable to services rendered, to Lamendola Dentistry.

FINANCE CHARGES

Be aware that any unpaid balance after 60 days is charged a yearly finance charge of 18% and that this finance charge is equal to 1.5% of the outstanding balance per month. If the account reaches collections status and no effort is made to pay it off, the account will be assigned to a collection attorney or agency. If the doctor must take additional steps to collect the account, all costs of collection including court costs and attorney's fees incurred by the doctor will be charged to the patient.

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Date_____ Signature_____

Phone_____ Approved By_____

Privacy Agreement

Lamendola Dentistry, Associates and Staff (hereinafter collectively referred to as "We" and "Dentist") agree to maintain the privacy of their patients as outlined in this HIPAA form. We take great care in being able to extend a higher level of privacy than is required by HIPAA, state confidentiality law and common law.

Due to the complex nature of State and Federal Privacy laws it has come to our attention that some dental offices are able to work around these laws. An example: Under HIPAA a dentist is not allowed to receive money for selling patient lists or protected health information to companies to market their products or services directly to patients without authorization. It is our understanding that there are dental practices that lawfully circumvent this limitation by allowing a third party to market the information. It is important to note that personal data is not in the possession of the company selling its products or services, but the patient may still receive unwanted solicitation. We do not agree with this manner of marketing and furthermore, we do not think it is in our patients' best interest. Therefore, we agree not to provide any list for marketing or to accept any payment for patient lists or protected health information to any third party for the purpose of marketing to our patients.

In consideration for treatment and the above additional protection of patient's privacy, Patient agrees to refrain from directly or indirectly publishing commentary that would reasonably be considered negative to the Doctor, the practice and/or the Doctor's Associates and Staff unless such commentary is explicitly required by law. We have invested a significant amount of resources in the development of our practice through our time, money and marketing and ask that you not defame, disparage or discuss the Doctor, the Associates, the Staff or our practice in a negative manner as it will cause serious damage to our practice.

We are adamant about our Patients' privacy as well as the practices' right to control its public image and privacy. Dentist and you agree to work together to prevent the publishing or broadcasting of commentary about the other party from being accessed in any media. This Agreement will be in force and enforceable for a period of the longer of (a) five years from our last date of service to Patient; or (b) three years beyond any termination of the Dentist-Patient relationship. As a matter of office policy, we are requiring all patients in our practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all our patients.

You, as the Patient, and we acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, both the Patient and Dentist agree to the right of equitable relief, including, injunctive relief and beyond. Should a breach of this Agreement result in litigation, the prevailing party in the litigation will be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive explanations to their satisfaction.

Patient Signature _____ Date_____

Smile evaluation

Though this form is optional, it helps us understand how we can better serve you.

Is there anything you would like to improve about your smile?	YES	NO
Do you ever wish your smile were more like the ones you see on TV?	YES	NO
Are you ever self-conscious about your teeth?	YES	NO
Do you ever avoid smiling in photographs or at social engagements?	YES	NO

If you answered YES to any of the above, check the following which apply to you:

- ☐ Wish teeth were whiter
- ☐ Wish teeth were straighter
- ☐ I feel I show too much gingiva (“gums“) when I smile
- ☐ I am bothered by the gaps between my teeth
- ☐ Want to change the size or shape my teeth (want them longer, shorter, wider, smaller)
- ☐ I dislike my chipped teeth or uneven edges
- ☐ Have old dental work that I find unattractive
- ☐ I dislike my wrinkles when I make facial expressions or at rest
- ☐ Other _____

What concerns do you have regarding the improvement of your smile:

- ☐ Fear of dental treatment
- ☐ Financial concerns
- ☐ Number/length of appointments
- ☐ Working appointments into my work schedule