LAMENDOLA DENTISTRY

&

LAM DENTISTRY

Date: ________________

Name: Dr./ Mr./ Mrs./Ms.

First _____________ Middle initial____ Last ________________

Address ____

City __________ State ____________ Zip ________

Status: (circle) Single Married Sex: M F

SS# ___________________________

Phones: Cell _______________ Home _______________

Date of Birth: ____/____/____

Email address: ___________________________________

Responsible Party: _____________________ Phone: _______________________

Relation: ___________________________

Emergency Contact: ________________________ Phone: ___________________

Relation: _________________________

How did you hear about us? **(Please circle one)**

Mail Ad Google Yelp Facebook Instagram Healthgrades

Person (who, we want to thank them): ______________________________

Health Information

Are you currently seeing a physician? ___ For what reason? ______________________________

Have you been hospitalized in the past year? ___ Why? _________________________________

Have you ever had a serious head or neck injury ___Why?________________________________

Physicians Name: __________________________

If you were regularly seeing a dentist, why did you change to our office? ___________________

Do you have history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**
AIDS/ HIV positive			Cold Sores/ Fever Blisters			Frequent Cough		
Anemia/ Hemophilia			Yellow Jaundice			Genital herpes		
Artificial Heart Valve			Drug Addiction			Heart Attack/ Failure		
Blood Disease			Epilepsy			Heart Trouble/ Disease		
Bruise Easily			Fainting/ Dizziness			High Blood Pressure		
Chest Pains			Frequent Headaches			High Cholesterol		
Convulsions			Hay Fever			Irregular Heartbeat		
Diabetes			Heart Pacemaker			Liver Disease		
Emphysema			Hepatitis A/B/C			Mitral Valve Prolapse		
Excessive Thirst			Anaphylaxis			Parathyroid Disease		
Venereal Disease			Arthritis/ Gout			Recent Weight Loss		
Glaucoma			Asthma			Rheumatism		
Heart Murmur			Chemotherapy			Sickle Cell Anemia		
Hemophilia			Congenital Heart Disease			Stomach/ Intestinal Disease		
Alzheimer’s Disease			Cortisone Medicine			Tumor or Growths		
Angina			Easily Winded			Hives or Rash		
Blood Transfusion			Excessive Bleeding			Kidney Problems		

Cancer			Hypoglycemia			Tuberculosis		
Osteoporosis			Leukemia					
Psychiatric Care			Lung Disease					
Renal Dialysis			Pain in Jaw Joints					
Scarlet Fever			Radiation Treatments					
Sinus Trouble			Rheumatic Fever					
Stroke			Shingles					
Tonsillitis			Spina Bifida					
Ulcers			Swelling of Limbs					

Are you ALLERGIC to:	**Y**	**N**		**Y**	**N**
Penicillin			Latex		
Aspirin			Sulfa Drugs		
Codeine			Acrylic		
Metal			Local Anesthetics		

Have you ever taken Phen- Fen or Redux? _______________

Have you ever taken Fosamax, Boniva, Actonel or any medication containing bisphosphonates? ___________________________

Do you smoke? __________

Do you take any controlled substances? __________________

Please list all medications you take: ______________________________

*LADIES ONLY: Are you pregnant? _____ Nursing? ____ Taking oral contraceptives? _____

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, Lam Dentistry, assistants, hygienists, and specialists of their choice to perform the following dental procedures:

Photographs, radiographs, study models, extraction and other surgical procedures, biopsies, periodontal cleaning and/ or surgery, illness, 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: 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. Paresthesia- permanent or temporary numbness of the cheek, 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 bite, TMJ dysfunction or worsening of the 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), leg(s), and disfiguring scars.

PHOTOGRAPHS: I hereby specifically authorize the above doctors and staff to take, develop and use photographs of patients' teeth at all phases of my treatment for educational, demonstrative and/or promotional purposes. Photographs do not include the patients face nor their name or any information pertaining to patient. I do hereby forever

waive any claim to royalties or other monies or other sources of reimbursement that are received from their use.

PRIVACY: I understand that matters relating to my treatment with Lamendola and Lam Dentistry are confidential. I will not engage in any form of communication (including but not limited to verbal, written, electronic and internet communication) that may reflect negatively on Lamendola or Lam Dentistry, its current or former employees, or current or former owners.

ACKNOWLEDGEMENT: 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 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 has 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 complications(s), where further treatment may be discussed, or administered, which is not currently anticipated.

I hereby authorize Lamendola Dentistry and Lam 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. I have read both pages of this consent form.

Patient Name____

Signature of Patient/ Guardian ________________________________

Date ____________________________________

Privacy Agreement

Lamendola Dentistry, Lam 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 HIPPA, 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 patient's 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 patients 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 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 ln 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 Name _________________ Patient/ Guardian Signature ____________________ Date _____________

Financial Policy

MISSED APPOINTMENTS: We ask that you notify our office at least 48 hours in advance if you cannot keep your scheduled appointment. If we do not receive a 48-hour notice, a $25 fee will be charged to your account.
REGARDING INSURANCE: We will gladly file all dental claims for a given treatment. However, 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 and Lam 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 and Lam 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% for 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 collections attorney or agency. If 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 charted to the patient.

Patient Name _____________________

Patient/Guardian Signature _________________________

Date ______________________________

Insurance Estimates

*Please skip this page if you do not have insurance

*Please skip this page if you do not have insurance
As a courtesy to our patients, we provide an estimate for what insurance will pay toward each treatment and we only collect the estimated patient portion on the day of treatment. Our estimates are based on info provided to us by your insurance on your yearly verification. Your insurance company takes no responsibility for the info given to us in advance. **Insurance companies can deny payment or downgrade a payment once they receive the claim, despite the information they provided to us in advance. Insurance companies do not notify us of changes to your plan.**

Our promise to you: We make every effort to provide an accurate insurance estimate.

Are you worried about insurance not paying the estimated amount and getting a bill later? Here are some options:

A. You can pay the full amount for treatment and we can pay you back when we receive insurance payment

B. You can request a pre-determination for your treatment plan. This is a request to your insurance company to provide estimates in writing for your specific treatment plan. Please note that predeterminations can take several weeks to come back, they have expiration dates and they are not guaranteed.

I have read and understand the above about the estimated insurance payments.

Signature____________________ 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 and/or Lam 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____

Smile Evaluation

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

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

o Fear of dental treatment

o Financial concerns

o Number/ length of appointments

Do you ever avoid smiling in photographs or at social engagements? YES NO

If you answered yes, which apply to you?

o Wish teeth were whiter

o Wish teeth were straighter

o I feel I show too much gingiva (gums) when I smile

o I am bothered by the gaps between my teeth

o I want to change the size or shape of my teeth (want them longer, shorter, wider, smaller, etc.)

o I dislike my chipped teeth or uneven edges

o I have old dental work that I find unattractive

o I dislike my wrinkles when I make facial expressions or at rest