Client Name_____ Client ID #200____

Welcome,

to Alberto Lamberti Dental Happiness

Welcome we are excited to help you. The benefits of a healthy, beautiful and functional smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve.

Please complete this thorough confidential form so that we can provide the best care possible for ***you***!

Important Information About You

Today's Date: / /

First Name:_____ Last Name:_____ Middle Name:_____

I would prefer to be called "_____" by Dr. Lamberti and his team.

Phones: Cell Phone: (_____)_____ Home Phone:(_____)_____.

Work Phone: (_____)_____ Fax Phone: (_____)_____.

* Email Address: _____@_____. (For Emergency use only)

Local Home Address:_____.

City:_____ State:_____ Zip:_____.

Northern Address:_____.
City:_____ State:_____ Zip:_____.

Northern Phone #: (_____)_____ Northern Cell: (_____)_____.

Whom may we thank for referring you?_____.

Employer:_____ Address:_____.

Date of Birth:_____/_____/_____ Age Now:_____Years

Marital status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed Spouse's Name:_____.
❒ Significant other: Significant Other's Name:_____Phone:_____.

Emergency Contact Information

In case of EMERGENCY, who should we call? Name: _____Phone #: (_____)_____.
Home Health Aid: Name:_____Phone #: (_____)_____.
Nearest relative not living with you? Name: _____Phone #: (_____)_____.
Nearest friend not living with you? Name: _____Phone #: (_____)_____.

Who is Responsible for this account:_____ Drivers License_____

Client Name_____ Client ID #200____

Medical History

We need all this information to help you. Thanks for completing these very important forms.

Name of personal physician:_____ Phone #:(____) _____-_____.
Last visit with Physician:_____ Current Health: ❒Excellent ❒Good ❒Fair ❒Poor

*****If you are taking Birth Control medications you must know that if you ever take antibiotics the birth control medication will no longer work, *you* will be at risk for becoming pregnant. x_____Initial here.**

Are you currently taking any medications? ❒Yes ❒No , If yes, please list below:

Name of Medication:	*Purpose:*	*Name of Medication:*	*Purpose:*
1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

Have you had any serious medical problem or have been hospitalized within the past five years? ❒Yes ❒No If yes, please explain:_____

_____

Have you experienced?

❒Yes ❒No **DO YOU NEED TO PREMEDICATE PRIOR TO YOUR DENTAL TREATMENT**

❒Yes ❒No Chest pain (angina)?
❒Yes ❒No Recent weight loss?
❒Yes ❒No Sinus problems?
❒Yes ❒No Frequent vomiting, nausea?
❒Yes ❒No Ringing in the ears?
❒Yes ❒No Blurred vision?
❒Yes ❒No Frequent urination?
❒Yes ❒No Joint pain, stiffness?
❒Yes ❒No Heart murmur?
❒Yes ❒No High blood pressure?
❒Yes ❒No Hepatitis? A, B or C?
❒Yes ❒No AIDS or ARC?
❒Yes ❒No Anemia, blood diseases?
❒Yes ❒No Kidney or bladder disease?
❒Yes ❒No Psychiatric care?
❒Yes ❒No Pacemaker?
❒Yes ❒No Aspirin taken regularly?
❒Yes ❒No Smoke/Chew Tobacco?

❒Yes ❒No Swollen Ankles?
❒Yes ❒No Persistent cough?
❒Yes ❒No Difficulty swallowing?
❒Yes ❒No Difficulty urinating?
❒Yes ❒No Diabetes?
❒Yes ❒No Herpes?
❒Yes ❒No Dry mouth?
❒Yes ❒No Heart disease?
❒Yes ❒No Rheumatic fever?
❒Yes ❒No TB, Emphysema?
❒Yes ❒No Stomach problems?
❒Yes ❒No Arthritis, Rheumatism?
❒Yes ❒No VD (Syphilis, Gonorrhea)?
❒Yes ❒No Thyroid disease?
❒Yes ❒No Prosthetic Heart valve?
❒Yes ❒No Contact lenses?
❒Yes ❒No Reaction to "novocaine"?
❒Yes ❒No Women: Are you pregnant?

❒Yes ❒No Shortness of Breath?
❒Yes ❒No Bleeding problems, bruising easily?
❒Yes ❒No Diarrhea, blood stools?
❒Yes ❒No Kidney Problems?
❒Yes ❒No Eye Diseases?
❒Yes ❒No Excessive thirst?
❒Yes ❒No Jaundice?
❒Yes ❒No Lung Diseases?
❒Yes ❒No Stroke? When:
❒Yes ❒No Heart Attacks? Defects?
❒Yes ❒No Family history of Diabetes?Who:
❒Yes ❒No Dizziness? When:
❒Yes ❒No Seizures? Last:
❒Yes ❒No Headaches? When:
❒Yes ❒No Artificial joint? Which:
❒Yes ❒No Recreational drugs?
❒Yes ❒No Fainting Spells? When:

❒Yes ❒No Cancer Treatments: Where:_____ Location on Body:_____ When:_____
❒Yes ❒No Chemotherapy Treatment: Where:_____ Location on Body:_____ When:_____
❒Yes ❒No Radiation Treatment: Where:_____ Location on Body:_____ When:_____
❒Yes ❒No Psychiatric care? When:_____ Diagnosis:_____ Last session:_____

Allergies to: ___ Penicillin ___Erythromycin ___Aspirin ___Dental Anesthetic ___Codeine ___Other:_____❒ None

Please explain if you have been treated for any other illnesses not listed above?

_____

_____

The above information is true and correct to the best of my knowledge:

✍_____ Date:__/__/__.

Client Name_____ Client ID #200____

Dental History

What is your reason for visiting with us today? What are your goals with respect to your dental, oral condition?

_____

_____

_____

How would you describe the conditions of your mouth, teeth and gums? ❒Good ❒Fair ❒Poor

Are your teeth sensitive to ❒hot ❒cold ❒sweets ❒biting pressure ❒just comes on by itself (Where?)_____

❒Yes ❒No Are you in pain now? (If yes,explain):_____.

❒Yes ❒No Have you had any problems with prior dental treatment?_____.

❒Yes ❒No Does your bite feel "off"; are your teeth hitting harder, more in one area, do you hit and then slide?

❒Yes ❒No Do you have difficulty with digestion?

❒Yes ❒No Pain in your jaw joint or ears? Headaches? Ear Aches?

❒Yes ❒No Do your gums bleed when you floss or brush?

❒Yes ❒No Do you have dry mouth?

❒Yes ❒No Have your teeth shifted?

❒Yes ❒No Do you grind your teeth?

❒Yes ❒No Would you like fresher breath?

❒Yes ❒No Do you get "fever blisters"? ___Lips? ___Inside mouth?

❒Yes ❒No Do you have an unpleasant taste or odor?

❒Yes ❒No Have you ever been in a Motor Vehicle Accident?

❒Yes ❒No Have you ever, in your life, had trauma to the head and neck or jaw area?

❒Yes ❒No Has fear of discomfort has kept you away from keeping regular dental visits.

❒Yes ❒No Do you wear a nightguard? How long ____yrs. If yes, (circle one please:) Upper or Lower

❒Yes ❒No Many patients consult with us for another opinion. Are you here for another opinion?

❒Yes ❒No Have you experienced pain in your jaw joint or has your jaw ever locked open or closed?

❒Yes ❒No Do you get frustrated because you always have something treated or repaired when you visit the dentist?

❒Yes ❒No Do you get headaches? Any kind of headaches? Describe:_____.

❒Yes ❒No Does/did your Jaw click or pop? If yes, do you still have it or did it go away?_____.

❒Yes ❒No Have you ever been treated for TMJ symptoms? (If yes, please explain):_____.

❒Yes ❒No Do you clench/grind your teeth? When?_____.

❒Yes ❒No Food gets stuck around and in between your teeth (circle where please:) Upper Right Upper Left Lower Right Lower Left

Please Do Not Write in this Area: Office Use Only

If you could wave a "*magic wand*", and change anything you could about the appearance of your smile what would you like to do? ❒Straighter ❒Whiter ❒Close Spaces ❒Longer ❒Shorter ❒More Even ❒Replace missing teeth ❒ Fresher breath ❒Replace uncomfortable partial dentures or full dentures Other comments:

How often do you brush your teeth? (Circle One) 1x/day 2x/day 3x/day

Floss your teeth: (Circle One) 1x/day 2x/day 3x/day

When was your last dental visit? _____ What was done for you?_____

Please rate your smile from 1-10: (1=I hate my smile) 1 2 3 4 5 6 7 8 9 10 (10=awesome) [Circle one please]

What is most important to you? **(Please check one)**

❒ The highest quality dentistry available ❒ The most economical treatment plan ❒ A combination of the above

What is your time frame, when would you like to begin?_____

What would you like to start with first?_____

The above information is true and correct to the best of my knowledge:

✍_____ Date:__/__/__.

Client Name_____ Client ID #200____

Welcome Alberto Lamberti, D.M.D., P.A.

WORLD CLASS FUNCTIONAL SMILES - OFTEN OVERNIGHT!

Welcome to your "new" dental home – we prefer to care for friends and we're glad you've chosen to be our client! Please let us know anything you feel we should know that will help enhance our relationship and help us to treat you in the manner you feel is best for you. Tell us what you didn't like about your previous dental experiences so that we don't duplicate that aspect of your experience when you are with us. We care enough to ask.

✍_____ Date: / / .

Previous/Current Northern Dentist:
Name:_____ Phone:_____
Address:_____

Previous/Current Periodontist:
Name:_____ Phone:_____
Address:_____

Previous Oral Surgeon:
Name:_____ Phone:_____
Address:_____

Previous Endodontist:
Name:_____ Phone:_____
Address:_____

Previous Orthodontist:
Name:_____ Phone:_____
Address:_____

Client Name_____ Client ID #200____

I understand that the information is correct to the best of my knowledge. I understand it will be held in the ***strictest confidence*** and only be used to improve communication between the Doctor and myself. I understand that I am inducing/authorizing Dr. Alberto Lamberti to perform professional services on my behalf and agree to be financially responsible for all expenses incurred and charged as a result of Dr. Alberto Lamberti rendering professional services, including *all* costs of collection associated therewith, including court costs and attorney's fees. In case of suit, you agree the venue shall be Boca Raton, FL, Palm Beach County. (We are proud to say that this has not become an issue in over 16 years in a row!) I also authorize disclosure of my record to the extent necessary to determine liability for payment and (to insurance companies etc). I also give permission for the Doctor to disclose my information with associated Doctors also rendering treatment for me, (associated physicians and dentists with Doctors whom have previously rendered treatment on my behalf). I also give permission for the Doctor or his staff to use any photos he may take to be used for lecturing and educational purposes.

Our Privacy Notice:

We are committed to maintaining the confidentiality, integrity and security of personal information entrusted to us by current and prospective clients. We want you to know how we protect your information and how we use it to service you. We hope you will take a moment to review our Privacy Policy.

You entrust us with personal information and we take that trust very seriously! We do not share any nonpublic personal information about you with any third parties except as necessary to assist you with your insurance needs, to coordinate and sequence your treatment with other associated specialists/generalists you have authorized to participate in your care and treatment or except as required by law. We restrict access to your personal information to those employees who need to know this information to provide the highest level of care and treatment for you. In addition, you can feel comfortable knowing we maintain physical and procedural safeguards to protect your personal information.

I have received a copy of this office's Notice of Privacy Practices.

_____ Date:___/_____/_____

Signature of Client (Patient)

_____

Please Print Name

_____ Date: ___/_____/_____

Parent (If Client is not of majority) or (Responsible Party if other than Client)

_____

Please Print Name

Client Name_____ Client ID #200____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect December 22, 2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations,
you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our

professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us
a letter to the address at the end of this Notice. If you request copies, we will charge you $0 for each page, $0 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to

Client Name_____ Client ID #200____
receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Alberto Lamberti, D.M.D.
Telephone: 561-338-7535 Fax: 561-368-2981
E-mail: Lambertismiles@gmail.com
Address: 240 W Palmetto Park Rd, #220 Boca Raton, FL 33432

Client Name_____ Client ID #200____

Alberto Lamberti, D.M.D., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please Specify)

_____

_____

_____