

Client Name_____

ALBERTO J. LAMBERTI, D.M.D.
Restorative, Cosmetic and Implant dentistry

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: (____) _____ Home: (____) _____

Work: (____) _____ Fax: (____) _____

* Email Address: _____@_____

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 ☐ Other

Spouse's Name: _____ Phone: (____) _____

Emergency Contact Information

In case of **EMERGENCY**, who should we call?

Name: _____ Phone #: (____) _____

Home Health Aid: Name: _____ Phone #: (____) _____

Client Name_____

Name of personal physician: _____ Phone: () _____

Last visit with Physician: _____ Current Health: ☐Excellent ☐Good ☐Fair ☐Poor

PHARMACY NUMBER: () _____

If you are taking birth control medication, please consult with your physician before taking any antibiotics.

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 problems or have been hospitalized within the past five years? ☐Yes ☐No If yes, please explain:

Have you experienced it?

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain (angina)? | <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen Ankles? | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Recent weight loss? | <input type="checkbox"/> Yes <input type="checkbox"/> No Persistent cough? | <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding problems, bruising easily? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty swallowing? | <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea, blood stools? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent vomiting, nausea? | <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty urinating? | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in the ears? | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye Diseases? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blurred vision? | <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive thirst? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent urination? | <input type="checkbox"/> Yes <input type="checkbox"/> No Dry mouth? | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Joint pain, stiffness? | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung Diseases? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur? | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever? | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke? When: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No TB, Emphysema? | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attacks? Defects? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis? A, B or C? | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No Family history of Diabetes? Who: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS or ARC? | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis, Rheumatism? | <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness? When: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia, blood diseases? | <input type="checkbox"/> Yes <input type="checkbox"/> No VD (Syphilis, Gonorrhea)? | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures? Last: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney or bladder disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches? When: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric care? | <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthetic Heart valve? | <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial joint? Which: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker? | <input type="checkbox"/> Yes <input type="checkbox"/> No Contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No Recreational drugs? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin taken regularly? | <input type="checkbox"/> Yes <input type="checkbox"/> No Reaction to "Novocain"? | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting Spells? When: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Smoke/Chew Tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No Women: Are you pregnant? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer Treatments: Where: _____ | Location on Body: _____ | When: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy Treatment: Where: _____ | Location on Body: _____ | When: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatment: Where: _____ | Location on Body: _____ | When: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric care? When: _____ | Diagnosis: _____ | Last session: _____ |

☐Yes ☐No **Allergies to: __ Penicillin __ Erythromycin __ Aspirin __ Dental Anesthetic __ Codeine __ Other**

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_____

Dental History

What is your reason for visiting with us today?

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 ☐ none

- ☐ 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 Pain in your jaw joint or ears? Headaches? Earaches?
- ☐ 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 Do you wear a nightguard? How long ___yrs. If yes, (circle one please:) Upper or Lower
- ☐ Yes ☐ No Have you experienced pain in your jaw joint or has your jaw ever locked open or closed?
- ☐ 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 Food gets stuck around and in between your teeth (circle where please:) Upper Right Upper Left Lower Right Lower Left

If you could change anything about the appearance of your smile, what would you like to do?

- ☐ Close Spaces ☐ Longer ☐ Shorter ☐ Replace missing teeth ☐ Straighter ☐ Whiter
- ☐ Fresher breath ☐ Replace uncomfortable partial dentures or full dentures
- ☐ Other comments: _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

When was your last dental visit? _____ Date of your last x-rays: _____

Type of toothbrush? ☐ Soft ☐ Medium ☐ Hard ☐ Electric

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



Date: ____/____/____

Client Name_____

Alberto Lamberti, D.M.D.,

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_____

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. I also authorize the 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_____

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

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.

Client Name_____

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.

Client Name_____

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 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

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Client Name_____

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