

# Welcome

## ABOUT YOU

Today's Date: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last First Mi Mr Mrs Ms Dr

I prefer to be called: \_\_\_\_\_ ☐ Male ☐ Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

**Home Address:** \_\_\_\_\_  
Street City State Zip

Home Phone #: (\_\_\_\_) \_\_\_\_\_ **CELL** : (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_ Whom may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

**Employer:** \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

## Person Responsible for Account if other than yourself

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Street City State Zip

## INSURANCE INFORMATION

**Primary Insurance** Dental Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

**Secondary Insurance** Dental Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

CONTINUED ON BACK



## DENTAL HISTORY

### Why have you come to the dentist today?

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Have you experienced problems associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

How long do you use a toothbrush before replacing it? \_\_\_\_\_

Do you use anything in addition to your brush and floss? ☐ Yes ☐ No

If yes, what? \_\_\_\_\_

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you have mobility in your teeth? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Do you still have wisdom teeth? ☐ Yes ☐ No

If yes, why? \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_  
(Please Circle)

Why did you leave your previous dentist? \_\_\_\_\_

What did you like most & least about any dentist you have seen? \_\_\_\_\_

**Are you happy with the way your smile looks?** ☐ Yes ☐ No

If not, what would you change? \_\_\_\_\_

## MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other Bisphosphonate? ☐ Yes ☐ No

### Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions: \_\_\_\_\_

**For Women:** Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: \_\_\_\_\_ Are you nursing? ☐ Yes ☐ No

### Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	Have you ever taken Phen-Fen? Also known as Redux or Pondimin. <input type="checkbox"/> Yes <input type="checkbox"/> No
Y N Aspirin	Y N Digitalis/Heart Medication	Y N Steroids/Cortisone	

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ☐ Yes ☐ No If yes, please list each one: \_\_\_\_\_

### Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Osteoporosis/Paget's Disease	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fever Blisters	Y N HIV+/AIDS	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for Any Reason	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: \_\_\_\_\_

## AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be \_\_\_\_\_.

Signature \_\_\_\_\_

Date \_\_\_\_\_

### PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by \_\_\_\_\_ Insurance Co. and I assign directly to Dr. \_\_\_\_\_ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature \_\_\_\_\_

Date \_\_\_\_\_





**George Lambrinos D.M.D.**  
Family And Cosmetic Dentistry

Tel: 732-446-6533  
Fax: 732-446-4287

Franklin Plaza  
557 Englishtown Road #13  
Monroe Township, NJ 08831

**Our Financial Policy**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE**

**WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS**

**WE ACCEPT CARE CREDIT. (Please speak to the office manager if you would like to use this option)**

**WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL**

**Regarding Insurance**

We will accept assignment of insurance benefits. However, we do require that you pay your co-payment of the bill at the time of service. The balance is your responsibility whether your insurance pays it or not. We cannot bill your insurance unless you provide us with your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require that you be pre-approved on you extended payment plan or provide a credit card with authorization to bill that account balance. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.

Regarding insurance plans where we are a participating provider. All co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.





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**Usual and Customary Rates**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Minor Patients**

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized to an approved credit plan, credit card, or payment by cash or check at the time the of the service has been verified.

**Missed Appointments**

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

**Financial Responsibility**

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney fees and costs of collection in the event of default. I further understand that if a payment becomes **30** days past due, delinquency at the lesser of the annual rate of **18%**, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. Thank you for understanding our Financial Policy.

I have read the Financial Policy, and I understand and agree to this Financial Policy.

X\_\_\_\_\_Date:\_\_\_\_\_  
Signature of Patient or Responsible Party

X\_\_\_\_\_Date:\_\_\_\_\_  
Signature of Co-Responsible Party

X\_\_\_\_\_Date:\_\_\_\_\_  
Signature of Office Manager





George Lambrinos D.M.D.  
Family And Cosmetic Dentistry

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557 Englishtown Road #13  
Monroe Township, NJ 08831

### APPOINTMENT CANCELLATION POLICY

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance.

Our staff wants to be available for your needs and the needs of all our patients. When someone fails to keep a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those not cancelled within 24 hours. **There will be a fee of \$50.00 assessed if we do not receive a call to cancel an appointment.**

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all of our patients.

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Patient Signature

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Date



# NOTICE OF PRIVACY PRACTICES

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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.

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## 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, 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 \$0.75 for each page, \$10 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 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: George Lambrinos DMD**

**Telephone: 732-446-6533**

**Fax: 732-446-4287**

**Email: [DMDKarp@gmail.com](mailto:DMDKarp@gmail.com)**

**Address: 557 Englishtown Rd. Suite 13, Monroe Township, NJ 08831**



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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* You May Refuse to Sign This Acknowledgement\*

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

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_