Welcome to our dental family. We appreciate the confidence and trust you have placed in us, and we look forward to meeting you and helping you with your dental needs. We believe in developing healthy and long lasting relationships with our patients.

Our mission is to help you keep your teeth for a lifetime in maximum comfort, function, health, and esthetics. To reach this goal in a realistic and appropriate manner, we will provide you with the information you need to make the appropriate decisions to accomplish that goal.

We provide a complete and thorough dental evaluation, gathering all pertinent information appropriate for each individual. We will review this information, establish a diagnosis, and life-long care program that will assist you in maintaining your personal dental health for a lifetime.

It is our pledge to provide you with complete and excellent dental care.

Please fill out the following forms and bring them with you to your initial visit.

Respectfully,

Howard G. Lashen, D.M.D.
Greggory J. Di Lauri, D.D.S.
and Staff

LASHEN & DILAURI
www.SmilesNJ.com
(973) 252.0030

Dental History

Do you have any current dental problems?____

1. Date of last complete dental examination?______________________________________
2. Are your teeth sensitive?____
3. Do your gums bleed or hurt?____
4. Have you noticed any loose teeth or change in your bite?___________________________
5. Have you noticed any mouth odors or bad tastes?_________________________________
6. Does food tend to become caught between your teeth?______________________________
7. Do you clench or grind your teeth?____
8. Have you ever had Orthodontic treatment?_______________________________________
9. Have you ever seen a Periodontist?____
10. Has your bite ever been adjusted?____
11. Do you have clicking or popping in your jaw?___________________________________
12. Do you have difficulty opening or closing your mouth?_____________________________
13. Have you ever been told you have a "TMJ" problem?________________________________
14. Do you get frequent headaches?____
15. Would you like to keep your teeth all your life?_________________________________
16. Are you anxious about dental treatment? _______________ If yes, what is your biggest concern?____
17. Have you ever had an upsetting dental experience? ______________ If yes, please describe____
18. Are you happy with the appearance of your teeth? _____________ If not, what would you like to change____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Relative

☐ Dental Office ☐ Phone Book ☐ Newspaper ☐ School ☐ Work ☐ Web Site

☐ Other _________________________________

Name of the person or office referring you to our practice: ____

Patient Information

Patient Name:____ Date:_______________

Last, First MI (Preferred Name)

Gender_____________ Family Status _____________

Email address: ____

Social Security #:___________________________ Birth Date______________________________

Phone (Home)__________________ (Work)________________ (Cell)_____________________

Address ____

Street Apartment #

____

City State Zip Code

Medical Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies __________ ________________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due Date:_________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ ________________
- ☐ ________________
- ☐ ________________

- Please list current medications:____

  ____

- Have you ever had any complications following dental treatment? ☐Yes ☐ No
  If yes, please explain:____

- Have you been admitted to a hospital or needed emergency care during the past 2 years? ☐Yes ☐No
  If yes, please explain:____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____

- Name of Physician ______________________________________ Phone ___________________

- Do you have any other health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors or staff at my next appointment.

____ Date ______________________

Signature of patient, parent or legal guardian

Responsible Party Information

Name:____

Email address: ____

Social Security #: ________________________ Birth Date: ________________________

Phone (Home) ______________ (Work) ________________ (Cell) ____________________

Address ____
Street Apartment #

____
City State Zip Code

Employer Name: __________________________ Occupation: ________________________

Address: ____
Street City, State Zip Code Phone Number

Insurance ID#: ____________________

Insurance Company Name ____

Address: ____
Street City, State Zip Code Phone Number

Are you covered by a second insurance company? ☐ Yes ☐ No

If yes please complete:

Insured's Name:______________________ Social Security # ________________________

Employer Name:__________________________ Occupation: ________________________

Address: ____
Street City, State Zip Code Phone Number

Insurance ID#____________________

Insurance Company Name ____

Address: ____
Street City, State Zip Code Phone Number

Consent for Services

1. I herby authorize the designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand that I can ask for a complete recital on any possible complication.

4. I agree to be responsible for payment of all services on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made.

5. I hereby give Dr. Lashen and Dr. Di Lauri the absolute right and permission to use my photographs / slides for educational or promotional purposes. The undersigned completely and forever releases any right or future compensation in connection with the use of said photographs / slides.

____________________________________ Date______________ Relationship to patient______________
Signature of patient, parent or guardian

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used to disclose by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal information.

AS required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspect of running our practice, such as conducting quality assessment and improvement activities, cost-management analysis, and customer service. An example would be an annual quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that

written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dr. Howard Lashen, D.M.D.
Dr. Greggory Di Lauri, D.D.S.
Town Center 66 Medical Building
66 Sunset Strip, Suite 307
Succasunna, NJ 07876

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly and individually.
- Obtain payment from third-party payers.
- Conduct normal health-care operations such as quality assessments and dentist certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of any health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to receive a current copy of the *Notice of Private Practices.*

I understand that my request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Please list persons with whom we may discuss your health information:

____

____ Date _______________

Signature of patient, parent or legal guardian

Authorization to Release Information

Dr. Howard Lashen, D.M.D.
Dr. Greggory Di Lauri, D.D.S.
Town Center 66 Medical Building
66 Sunset Strip, Suite 307
Succasunna, NJ 07876

I hereby authorize the above named dentists to provide any insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluation and administering claims for benefits.

____ Date_______________
Signature of patient, parent or legal guardian

THREE IMPORTANT COMMMITMENTS

A commitment between two people builds trust. We have three important commitments in our practice.

We have put them in writing because we live by them, as does our staff. We realize that the institution of these three commitments may be different from what you may have been accustomed to in other dental practices; however, we believe that these commitments are necessary in building the trust that it takes for us to successfully work together.

COMMITMENT TO TREATMENT

Dental disease is nearly 100% preventable. Therefore, we believe that all treatment initiated should be completed in a timely manner. We will deliver the best dental care possible and we ask that you care for your dental health on a daily basis. Incomplete treatment leads to unnecessary problems and complications, such as the loss of teeth. It also leads to more advanced disease which unnecessarily adds to your cost and can lead to a breakdown in communication. We know that you want as little dentistry done in your lifetime as possible. Help yourself achieve that by following through with your dental plan.

COMMITMENT TO APPOINTMENT

We will reserve time for you. We will give you our utmost attention and will rarely keep you waiting. An appointment scheduled in our office is a **bond of trust** that we will be here to serve you and that you will be on time and prepared for your appointment.

COMMITMENT TO FINANCIAL CONSIDERATIONS

We believe that we have a responsibility to use our best professional care, skill, and judgment in helping you achieve your dental health goals. As we have stated above, we believe dental disease is nearly 100% preventable. We will deliver the best dental care that we are capable of delivering to help you attain your goals. It is up to you to abide by the financial agreements that are discussed prior to treatment.

Signature ____ Date ______________________