



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,

Greggory J. Di Lauri, D.D.S.  
and Staff

**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:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| _____                                      | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries       | Due Date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | <b>OTHER:</b>                               |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |   |

• 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.

\_\_\_\_\_  
Signature of patient, parent or legal guardian Date \_\_\_\_\_

### **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: \_\_\_\_\_

## 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 hereby 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 dependents. I understand that payment is due at the time of service unless other arrangements have been made.
5. I hereby give 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.

\_\_\_\_\_  
Signature of patient, parent or guardian

Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**Greggory J. Di Lauri, D.D.S.**

Town Center 66 Medical Building

66 Sunset Strip, Suite 307

Succasunna, NJ 07876

Phone: (973) 252-0030 | Website: [www.SmilesNJ.com](http://www.SmilesNJ.com)

## 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.**

This Notice describes how we may use and disclose your protected health information (PHI) and how you can access this information. PHI includes information about your health, the care you receive, and payment for your care.

### Your Rights

- Get a copy of your paper or electronic dental record
- Correct your paper or electronic dental record
- Request confidential communications
- Ask us to limit the information we use or share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### How We May Use and Share Your Information

- **Treatment:** We may use your information and share it with other professionals who are treating you.
- **Payment:** We may use and share your information to bill and obtain payment from health plans or other entities.
- **Health Care Operations:** We may use your information to run our practice, improve care, and contact you when necessary.

### Other Permitted or Required Uses

- Public health and safety reporting
- Health oversight activities
- Law enforcement or court orders
- Workers' compensation claims
- As required by federal or state law

### Special Protections for Reproductive Health Information

Federal law prohibits us from using or disclosing protected health information for certain investigations or proceedings related to lawful reproductive health care. In certain situations, we may be required to obtain a signed attestation that a requested disclosure is not for a prohibited purpose.

## **Our Responsibilities**

- Maintain the privacy and security of your protected health information.
- Provide you with this Notice of our legal duties and privacy practices.
- Notify you following a breach of unsecured protected health information.
- Follow the duties and privacy practices described in this Notice.

## **Questions or Complaints**

If you believe your privacy rights have been violated, you may file a complaint with our office at the address above or with the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

**Effective Date:** February 16, 2026

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**Dr. Gregory 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:

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\_\_\_\_\_  
Signature of patient, parent or legal guardian

\_\_\_\_\_  
Date

**Authorization to Release Information**

**Dr. Gregory 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.

\_\_\_\_\_  
Signature of patient, parent or legal guardian

Date \_\_\_\_\_

# THREE IMPORTANT COMMITMENTS

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 \_\_\_\_\_