Thomas R. Lambert, DMD, MAGD
2299 Brodhead Road, Suite E
Bethlehem, PA 18020

Completion Instructions

Please print the forms, complete them and bring them with you on your first appointment visit.

If you have questions regarding these instructions, please contact our office at (610) 868-9928.

Thank you,

THOMAS R. LAMBERT, D.M.D., M.A.G.D.

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Bethlehem, PA 18020

Welcome to Always About Smiles. We sincerely appreciate you choosing our office for your dental and oral health care needs. Please be assured that we will work hard to continually earn the trust you have placed in us.

In order for us to serve you better, please take several minutes to complete this information form as thoroughly as possible.

Please tell us about yourself

Today's Date: _____

Patient's Name: _____ I prefer to be called: _____
Please circle one: Single Married Divorced Separated Widowed
Address: _____
City: _____ State: _____ Zip: _____
Email: _____ Preferred method of contact: (please circle) phone email text
Home Phone: _____ Best time to reach you: _____
Work #: _____ Cell #: _____
Date of Birth: _____ Sex: ☐M ☐F Social Security #: _____
Do you have dental insurance: ☐**Yes** ☐**No**
Have you visited our website? ☐**Yes** ☐**No**

If the Patient is a minor, please tell us about you, the parent or guardian:

Your name: _____ Relationship to Patient: _____
Your address: _____
City: _____ State: _____ Zip: _____
Your Home Phone: _____ Cell #: _____ Your Social Security #: _____

Employer information

Employer Name: _____ Business Phone: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Your Position: _____ How long with company: _____

Responsible Party Information

Person responsible for this account: _____ Social Security #: _____
Address: _____ Date of Birth: _____
(If different from above) Home #: _____
Employer and Address: _____ Cell Phone: _____
City: _____ State: _____ Zip: _____

Primary Insurance Information

Name of Insurance Company: _____ Phone #: _____

Plan Name or Number: _____ Member ID #: _____
Name of Person Insured: _____ Group #: _____
Social Security # of Insured: _____ Insured Date of Birth: _____

Secondary Insurance Information

Name of Insurance Company: _____ Phone #: _____
Plan Name or Number: _____ Member ID #: _____
Name of Person Insured: _____ Group #: _____
Social Security # of Insured: _____ Insured Date of Birth: _____

Name of Person to Notify In Case of Emergency: _____
Relationship: _____ Home Phone #: _____
Work #: _____
Cell #: _____

CONSENT

The undersigned hereby authorized the Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I understand that fee estimates for dental care can only be extended for a period of three (3) months from the date of the patient examination. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child): _____ Date: _____

DENTIST Signature: _____

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PATIENT MEDICAL FORM

Are you under a physician's care now? ☐Yes ☐No If yes, please explain: _____

Have you ever been hospitalized or had a major operation: ☐Yes ☐No If yes, please explain:
_____

Have you ever had a serious head or neck injury: ☐Yes ☐No If yes, please explain: _____
_____

Are you on a special diet? ☐Yes ☐No If yes, please explain: _____
Have you ever taken Fen-Phen, Redux or other diet drugs? ☐Yes ☐No If yes, please explain:
_____

Have you had any metal rods, pins or implants placed? ☐Yes ☐No If yes, please explain: _____
_____

Do you use tobacco? ☐Yes ☐No If yes, how much? (packs/day/yr) _____
If quit, when? _____
Have you used chew tobacco/snuff? ☐Yes ☐No If yes, how much? _____
Do you use controlled substances? ☐Yes ☐No If yes, please explain: _____
_____

Have you taken bisphosphonates such as Fosamax, Boniva or other osteoporosis medications? ☐Yes ☐No If yes, please explain: _____
How many alcoholic drinks per week? _____
Do you use recreational drugs? ☐Yes ☐No _____
(Your answers will be strictly confidential. Your safety is extremely important to us. Please realize that our office use of anesthetics and your use of cocaine, for example, can result in a fatal heart attack)
Do you take aspirin on a daily basis? ☐Yes ☐No
Do you have any disease, organ transplant or take any medications which may depress your immune system? ☐Yes ☐No

WOMEN: Are you? ☐ Pregnant ☐ Trying to get pregnant ❖Might be pregnant
☐ Nursing ☐ Taking oral contraceptives

MEDICATIONS: List any medications, pills or drugs you are currently taking: _____
_____
_____
_____

ALLERGIES: Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Soy	☐ Egg
☐ Acrylic	☐ Metal	☐ Local Anesthetics	☐ Dyes	☐ Latex
☐ Iodine	☐ Sulfa	☐ Other		

If Other, please explain: _____

Is there anything you would like to discuss with Dr. Lambert in private? _____
_____
_____

HEALTH HISTORY: Do you currently have, or have you ever had, any of the following conditions?

- ☐ **AIDS/HIV POSITIVE**
- ☐ **ALZHEIMER'S DISEASE**
- ☐ **ANAPHYLAXIS**
- ☐ **ANEMIA**
- ☐ **ANGINA**
- ☐ **ARTHRITIS/GOUT**
- ☐ **ARTIFICIAL JOINT**
- ☐ **ASTHMA**
- ☐ **ATOPIC (ALLERGY PRONE)**
- ☐ **BACK PROBLEMS**
- ☐ **BLOOD DISEASE**
- ☐ **BLOOD TRANSFUSION**
- ☐ **BREATHING PROBLEM**
- ☐ **BRUISE EASILY**
- ☐ **CANCER**
- ☐ **CHEMOTHERAPY**
- ☐ **CHEMICAL/ SUBSTANCE**
- ☐ **DEPENDENCY**
- ☐ **CHEST PAINS**
- ☐ **COLD SORES/FEVER BLISTERS**
- ☐ **CONGENITAL HEART DISORDER**
- ☐ **CONVULSIONS**
- ☐ **CORTISONE MEDICINE**
- ☐ **DEPRESSION**
- ☐ **DIABETES**
- ☐ **DRUG ADDICTION**
- ☐ **EAR CONGESTION**
- ☐ **EASILY WINDED**
- ☐ **EATING DISORDERS**
- ☐ **EMPHYSEMA**
- ☐ **ENDOCARDITIS**
- ☐ **EPILEPSY OR SEIZURES**
- ☐ **EXCESSIVE BLEEDING**
- ☐ **EXCESSIVE THIRST**
- ☐ **FAINTING SPELLS/DIZZINESS**
- ☐ **FEVER BLISTERS/COLD SORES**
- ☐ **FREQUENT COUGH**
- ☐ **FREQUENT DIARRHEA**
- ☐ **GENITAL HERPES**
- ☐ **GLAUCOMA**
- ☐ **HAY FEVER**
- ☐ **HEADACHES/MIGRAINES**
- ☐ **HEART ATTACK/FAILURE**
- ☐ **HEART MURMUR**
- ☐ **HEART PACEMAKER**
- ☐ **HEART TROUBLE/DISEASE**
- ☐ **HEMOPHILIA**
- ☐ **HEPATITIS A**
- ☐ **HEPATITIS B or C**
- ☐ **HERPES**
- ☐ **HIGH BLOOD PRESSURE**
- ☐ **HIVES OR RASHES**
- ☐ **HUMAN PAPILLOMA VIRUS (HPV)**
- ☐ **HYPOGLYCEMIA**
- ☐ **IRREGULAR HEARTBEAT**
- ☐ **JOINT REPLACEMENT**
- ☐ **KIDNEY PROBLEMS**
- ☐ **LEUKEMIA**
- ☐ **LIMITED JAW OPENING**
- ☐ **LIVER DISEASE**
- ☐ **LOW BLOOD PRESSURE**
- ☐ **LUNG DISEASE**
- ☐ **MITRAL VALVE PROLAPSE**
- ☐ **MOUTH PIERCINGS**
- ☐ **NECK PAIN**
- ☐ **PAIN IN JAW JOINTS**
- ☐ **PARATHYROID DISEASE**
- ☐ **PSYCHIATRIC CARE**
- ☐ **RADIATION TREATMENTS**
- ☐ **RECENT WEIGHT LOSS**
- ☐ **RENAL DIALYSIS**
- ☐ **RHEUMATIC FEVER**
- ☐ **RHEUMATISM**
- ☐ **SCARLET FEVER**
- ☐ **SHINGLES**
- ☐ **SICKLE CELL ANEMIA**
- ☐ **SINUS TROUBLE**
- ☐ **SLEEP APNEA**
- ☐ **SPINA BIFIDA**
- ☐ **STOMACH/INTESTINAL**
- ☐ **DISEASE**
- ☐ **STROKE**
- ☐ **SURGICAL IMPLANTS**
- ☐ **SWELLING OF LIMBS/ANKLES**
- ☐ **THYROID DISEASE**
- ☐ **TINNITUS/RINGING IN EAR**
- ☐ **TONSILLITIS**
- ☐ **TUBERCULOSIS**
- ☐ **TUMORS OR GROWTHS**
- ☐ **ULCERS**
- ☐ **VENEREAL DISEASE**
- ☐ **YELLOW JAUNDICE**

CONSENT

To my best knowledge, all of the information above is correct and, if any changes occur in my health or medications, I will inform the practice. I also consent to release health information to aid in my care and treatment from any healthcare provider this practice should contact. I also hereby consent to allow diagnosis and dental treatment to be performed by this practice for myself until further notice. I understand there are no guarantees in health or dental care.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

Always About Smiles
Exceeding Your Expectations In Everything We Do

YOUR DENTAL HEALTH

Name: _____ **Date:** _____

1. What is your primary concern that you would like us to address first? _____
   _____
2. When would you like us to start treatment? _____
3. Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? ____ YES ____ NO
   Is so, explain: _____
4. What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____
5. When was your last dental appointment?_____
   What was done then? _____
   When was your last dental cleaning? _____
6. Have you ever experienced: (please circle)

Prolonged bleeding	YES	NO	Accident or Injury	YES	NO
Extraction complication	YES	NO	Root Canal Treatment	YES	NO
Sores or lumps in mouth	YES	NO	Clenching or grinding of teeth	YES	NO
Difficulty chewing	YES	NO	Braces (orthodontia)	YES	NO
Clicking or locking of jaw	YES	NO	Bleeding gums	YES	NO
Jaw pain	YES	NO	Gum (periodontal) treatment	YES	NO
Headaches or Migraines	YES	NO	Loose teeth	YES	NO
Bad Breath	YES	NO	Sensitive teeth	YES	NO
Teeth Ground or Bite Adjusted	YES	NO	Problems with Novacain	YES	NO
Food getting caught between your teeth	YES	NO			

7. Do you have removable full dentures or partial dentures? YES NO
   If YES, how do they work for you? _____
8. What causes you twinges of pain? ____ Hot ____ Cold ____ Sweet ____ Sour ____ None ____ Bite
   Do you chew on only one side of your mouth? ____ YES ____ NO
   If YES, please explain: _____
9. Do you use (please circle): Water pic, Electric toothbrush, Fluoride rinse, Mouthwash
   How often do you brush your teeth? _____ times a _____
   How often do you floss? _____ times a _____
   What type of a brush do you use? _____ Manual _____ Powered
   Do you avoid brushing any part of your mouth because of pain? ____ YES ____ NO
   If YES, what part? _____
10. Do you clench your teeth? ____ YES ____ NO
    Do you bite cheeks/lips? ____ YES ____ NO
11. Do you have missing teeth? ____ YES ____ NO
    How long have they been missing? _____
    Why didn't you have them replaced? _____
    Was it ever suggested? _____
12. Do you have a time frame for completion of treatment for a special event? Wedding?
    _____

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COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please bring a copy of this information with you for your visit.

- Patients find that if they take an analgesic/anti-inflammatory prior to treatment it helps later in the day. Please ask us for our recommendation for your anticipated treatment prior to your visit.

- We provide various levels of sedation to ease your mind.
  Would you benefit from a sedative? _____ Yes _____ No

  If yes, we provide ____ Nitrous Oxide (laughing gas)
  ____ Mild sedative (oral medication)*

  *Note: With mild sedative, you will need someone to drive you to/from the appointment.

- Do you dislike the numb feeling that lingers after you receive local anesthetic? We now offer OraVerse®. OraVerse® is the first and only product to rapidly reverse the effects of your local dental anesthetic and bring you back to normal sensation in half the time.
  Would you be interested in learning more about it? ____ Yes ____ No

- Our treatment rooms are equipped with cable TV and FM Stereo/CD players. Watching TV or listening to your favorite music is an excellent way to pass the time during your visit. Please let us know what your favorite music is and at your next appointment, we will make sure we have it for you to listen to.

- Refreshing and cold water before treatment can help calm a nervous cough or dry throat.
  Would you like a chilled water drink? ____ Yes ____ No

- We realize your attention may be drawn to family or business concerns during treatment. We would be happy to oversee your children's play in our dedicated kids arcade area or monitor your cell phone for that important family or business call should you be unable to answer.

- Blankets help keep you warm and relaxed through your visit.
  Would you like a blanket? ____ Yes ____ No

- Pillows provide an extra measure of comfort if you have a sore back or neck.
  Would you like a pillow? ____ Yes ____ No

- For sensitive eyes, sunglasses will reduce glare and brightness from overhead lights.
  Would you like sunglasses? ____ Yes ____ No

- Is there anything else we can do to make your visit comfortable?
  _____
  _____
  __

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Please Handle Me With Care

We are committed to taking the time to get to know you, discuss your concerns, your fears and your dental expectations. Please check off your appropriate responses below and bring it with you on your first visit.

_____ **Novocain does not work well with me**

_____ **I gag easily**

_____ **I need to be in control when I'm lying in the dental chair**

_____ **I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and dental hygiene**

_____ **Pain relief is a top priority for me**

_____ **I don't like shots (or I've had a bad reaction to shots)**

_____ **Please tell me what I need to know about my mouth in order to make an informed decision**

_____ **My teeth are very sensitive**

_____ **I don't like the sound of the tool that makes picking and scraping noise**

_____ **I don't like cotton in my mouth**

_____ **I hate the noise of the drill**

_____ **Please respect my time. I don't want to be left sitting.**

_____ **I want to know the cost up front. No money surprises please.**

_____ **I have difficulty listening and remembering what I hear when sitting in a dental chair**

_____ **I have health problems and questions that we need to discuss**

_____ **I tend to look at the details instead of the big picture**

_____ **I prefer long-lasting solutions which may initially cost more over lower cost temporary solutions**

_____ **I prefer to talk to Dr. Lambert in technical rather than non-technical terms**

_____ **I like to be presented with the best treatment option versus having multiple compromised options**

_____ **I rely on professional maintenance rather than self-maintenance**

_____ I determine the extent of my treatment rather than relying largely on my dental insurance

_____ I usually see no reason to delay care and will not wait until I must act

In weighing my dental health decisions, I rank 1 to 5:

_____ Physical Discomfort

_____ Money

_____ Fear/Anxiety

_____ Personal Effort

_____ Time

In order of importance, I generally consider the following benefits ranked 1 to 7:

_____ Comfort

_____ Precision

_____ Function

_____ Peace of mind

_____ Health

_____ Durability

_____ Appearance

Please tell us about any past bad dental experiences:

_____

_____

Why are you consulting us rather than your previous dentist?

_____

_____

Is there anything else we can do to make your visit more comfortable?

_____

_____

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SMILE EVALUATION

Please use a full face mirror 12" – 14" from your face and look at your smile specifically with each question in mind. (It is helpful to have a friend ask you the questions).

Last Name	First Name	Middle	Date
_____	_____	_____	_____

1. Do you like the overall appearance of your teeth, your smile? ____ YES ____ NO
   If NO, please describe _____
   _____
2. Are your teeth as straight as you would like them to be? ____ YES ____ NO
   If NO, please describe _____
   _____
3. Do you have spaces between your teeth that you don't like? ____ YES ____ NO
   If YES, please describe _____
   _____
4. Do you like the color, length, width and shape of your teeth? ____ YES ____ NO
   If NO, please describe _____
   _____
5. Do your teeth have unattractive stains?
   - ____ Tobacco stains
   - ____ Coffee/tea stains
   - ____ Discolored fillings
   - ____ Tetracycline stains
   - ____ Silver filling stains
   - ____ Other _____
6. Do you think you have a "gummy smile"? ____ YES ____ NO
   If YES, please describe _____
   _____
7. Do you think that your teeth are attractive? ____ YES ____ NO
   - ____ Chipped
   - ____ Overlapping
   - ____ Protruding
   - ____ Excessively worn
   - ____ Hidden
   - ____ Artificial looking
   - ____ Missing
8. Do you like the way that your upper and lower teeth come together? ____ YES ____ NO
   If NO, please describe _____

_____

9. Do you consider that your existing fillings or dental work is unattractive? ____ YES ____ NO
   If YES, please describe _____
   _____

10. Do you think that your gums are unattractive? ____ YES ____ NO
    - ____ Swollen
    - ____ Reddened
    - ____ Bleed easily
    - ____ Excessively receded
    - ____ Crowns are ill-fitting or darkened edges
    - ____ Difficult to clean between teeth

11. What would you like to change the most in the appearance of your teeth, your smile?
    _____
    _____
    _____
    _____
    _____
    _____

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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 April 27, 2009, 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, $20.00 per hour for staff time to 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.

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HIPPA Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____

Birthdate: _____

Signature: _____

Date: _____