



**SPRING LAKE DENTAL CARE**  
**Dr. Peter E. Ciampi & Associates**  
**PATIENT REGISTRATION**

Thank you for choosing our dental practice to help you maintain your oral health. In order for our staff to provide you with the best possible oral health treatment, we ask you to complete the following form. The personal data will assist us in the administration of your account, for example dental insurance. The medical information is needed for an accurate diagnosis of your overall condition and helps identify any precautionary measures needed to protect your health. The information you provide will be kept strictly confidential.

**PERSONAL DATA**

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE NUMBERS: HOME \_\_\_\_\_ WORK \_\_\_\_\_  
CELL \_\_\_\_\_ EMAIL \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR BILLING: \_\_\_\_\_

OCCUPATION / PLACE OF EMPLOYMENT \_\_\_\_\_  
MARITAL STATUS \_\_\_\_\_ NAME OF SPOUSE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

**DO YOU HAVE DENTAL INSURANCE?** \_\_\_\_\_

INSURANCE POLICYHOLDER: \_\_\_\_\_  
PATIENT RELATIONSHIP TO THE INSURED: \_\_\_\_\_  
NAME OF INSURANCE COMPANY: \_\_\_\_\_  
INSURED'S EMPLOYER: \_\_\_\_\_  
INSURANCE ID#: \_\_\_\_\_  
GROUP/PLAN #: \_\_\_\_\_  
CLAIMS MAILING ADDRESS: \_\_\_\_\_

SECONDARY DENTAL INSURANCE? \_\_\_\_\_  
INSURANCE POLICYHOLDER: \_\_\_\_\_  
PATIENT RELATIONSHIP TO THE INSURED: \_\_\_\_\_  
NAME OF INSURANCE COMPANY: \_\_\_\_\_  
INSURED'S EMPLOYER: \_\_\_\_\_  
INSURANCE ID #: \_\_\_\_\_  
GROUP/PLAN #: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:**

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

\_\_\_\_\_  
Patient or Authorized Guardian's Signature

\_\_\_\_\_  
Date



## MEDICAL HISTORY

General Health (Please circle): Excellent Average Poor

Physician's name and address: \_\_\_\_\_

When did you have your last complete physical examination? \_\_\_\_\_

Are you being treated for anything now? Yes or No? If yes, please explain: \_\_\_\_\_

Recent Surgery? Yes or No? If yes, please explain: \_\_\_\_\_

Did you ever have (Please circle):

- |                     |              |                          |
|---------------------|--------------|--------------------------|
| • Joint Replacement | Pacemaker    | Kidney Disease,          |
| • Liver Disease     | Anemia       | Epilepsy                 |
| • Heart Trouble     | Thyroid      | Hepatitis                |
| • Venereal Disease  | Heart Murmur | HIV Positive Other _____ |

Is your blood pressure: High, Low or Normal?

Have you ever been told you need an antibiotic before dental treatment? If yes, please explain \_\_\_\_\_

Have you ever been treated with radiation? \_\_\_\_\_

Are you allergic to: (Please circle) Penicillin, Codeine or Novocaine?

Are you allergic to any other drugs? (Please specify) \_\_\_\_\_

Are you taking Birth Control Pills? \_\_\_\_\_

Are you taking any medications or Herbal Supplements? \_\_\_\_\_

If so, please list: \_\_\_\_\_

If Female: Are you pregnant? \_\_\_\_\_ Due Date \_\_\_\_\_

Are you subject to prolonged bleeding? \_\_\_\_\_

Do you smoke? Yes or No

If yes, please specify: number of cigarettes per day \_\_\_\_\_ pipe \_\_\_\_\_ cigars \_\_\_\_\_

## DENTAL HEALTH HISTORY

Date of last dental exam \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

Do you have any pain in your teeth because of heat, cold or sweets? \_\_\_\_ If so, where? \_\_\_\_\_

Do you have any pain in any part of the mouth or in any tooth while biting or chewing? \_\_\_\_ If so where? \_\_\_\_\_

Does food catch between your teeth? \_\_\_\_ If so, where? \_\_\_\_\_

Do your gums bleed, either in chewing or brushing or at any other time? \_\_\_\_ If so, when? \_\_\_\_\_

Do you clench your teeth during the day? \_\_\_\_ Have you been made aware of clenching your teeth during the night? \_\_\_\_

Do you experience frequent headaches? \_\_\_\_\_

Do you experience clicking, popping or pain in your jaw? \_\_\_\_\_

How often do you brush and floss your teeth? \_\_\_\_\_

Do your gums feel irritated, tender or swollen? \_\_\_\_\_

Are you completely happy with the appearance of your teeth? \_\_\_\_\_

How often do you have calculus (tartar) removed? \_\_\_\_ every \_\_\_\_ months \_\_\_\_\_

Would you like some information about Cosmetic Dentistry to improve your smile? \_\_\_\_\_

Or making your teeth whiter? \_\_\_\_\_

Are you interested in learning about preventing bad breath? \_\_\_\_\_

The information given above is accurate and true to the best of my knowledge.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dr.'s Signature

\_\_\_\_\_  
Date



SPRING LAKE DENTAL CARE  
DR. PETER CIAMPI AND ASSOCIATES

**REQUEST FOR CONFIDENTIAL COMMUNICATIONS & PATIENT RECORD OF DISCLOSURE**

**Name of Patient:** \_\_\_\_\_

(Please print)

**Date of Birth:** \_\_\_\_\_

I request that all communications to me (by telephone, mail, email, text) by Spring Lake Dental Care and/or its staff regarding appointment, treatment, insurance, my account and special promotions be handled in the following manner.

- Email Communications: Yes \_\_\_\_\_ No \_\_\_\_\_
- Text Communications: Yes \_\_\_\_\_ No \_\_\_\_\_
- Written Communications
  - Ok to use home address: Yes \_\_\_\_\_ No \_\_\_\_\_
  - Ok to use work/office address: Yes \_\_\_\_\_ No \_\_\_\_\_
- Oral Communications:
  - Home telephone number: \_\_\_\_\_
  - Cell telephone number: \_\_\_\_\_
  - May we leave a detailed message? Yes \_\_\_\_\_ No \_\_\_\_\_
  - Work telephone number: \_\_\_\_\_
  - May we leave a message with call back number: Yes \_\_\_\_\_ No \_\_\_\_\_

\*\* I understand that I can withdraw my consent at any time.

Dr. Peter Ciampi and his staff have my authorization to communicate with or release information to: (i.e. your medical doctors, family members, friends, companions, etc.)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use, or disclosure of, and requests for PHI (Protected Health Information) to the minimum necessary to accomplish the intended purpose. These provisions do not apply to users or disclosures made pursuant to an authorization requested by the individuals.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO (Treatment Payment Operations) may be permitted without prior consent in an emergency.

I give my permission for Spring Lake Dental Care to release records to other doctors, insurance companies, disability correspondence and labs pertinent to my medical treatment. Yes \_\_\_\_\_ No \_\_\_\_\_

**Patient Signature or Legal Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_



DR. PETER CIAMPI AND ASSOCIATES  
Tel: (732) 449-5666 Fax: (732) 449-5338

---

## Our Financial Policy

*Thank you for choosing us as your healthcare 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 you to read and sign prior to any treatment.*

**All patients must complete our information form in its entirety before seeing the doctor.**

**FULL PAYMENT IS DUE AT TIME OF SERVICE ACCORDING TO THE GUIDELINES OF YOUR PLAN.  
WE ACCEPT CASH, CHECKS, OR ATM/CREDIT CARDS.**

▪ **Regarding Your Insurance**

Your insurance policy is contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance policy. In the event that we do not accept assignment of benefits, we require that you provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to your responsibility. Please be aware that some and perhaps all of the services that are provided may be uncovered services, and not considered reasonable and necessary under the Medicare program and/or other media insurances.

▪ **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 out area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

▪ **Adult Patients**

Adult patients are responsible for full payment according to their plan at the time of service.

▪ **Minor Patients**

Minor must be accompanied by a parent or a guardian. He adult accompanying the minor is responsible for full payment. Unfortunately, we cannot get involved in divorce and custody matters.

▪ **Missed Appointments**

Your appointment has been especially reserved for you, unless 48 hour rescheduling notice is given, a fee will be charged. This fee is not reimbursable by your dental insurance and must be paid before your next appointment us schedules. The rate for the time you reserved is \$450/hr for the doctor and \$155/hr for the hygienist.

▪ **Past Due Accounts**

All accounts not paid within 30 days of the bill date will be charged interest at a rate of 1.5% per month.

**I HAVE READ THE FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THESE TERMS**

---

Print Name

Signature of Patient of Responsible Party

Date



**Dr. Peter E. Ciampi & Associates**  
310 Morris Avenue  
Spring Lake, NJ 07762  
732-449-5666

**SPRING LAKE DENTAL CARE**  
**CONSENT TO PERFORM DENTISTRY**

1. I hereby authorize and direct the dentist's of Spring Lake Dental Care and/or dental auxiliaries of their choice, to perform the following dental treatment or oral surgery procedure (s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
  - A. Hygiene treatment (prophylaxis) and the application of topical fluoride.
  - B. Application of plastic "sealants" to the grooves of the teeth.
  - C. Treatment of diseased or injured teeth with dental restorations (fillings).
  - D. Treatment of diseased or injured oral tissues (hard and/or soft).
  - E. Use of sedative drugs to control apprehension.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risk (s) will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request performances of any additional procedures that are deemed necessary or desirable to oral health up to the professional judgment of the dentist.
5. There are possible risk and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these being swelling, bleeding, pain, nausea, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site) fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the risks and complication.
6. I also authorize the doctor(s) to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching research and scientific publications.
7. I have been advised that the success of the dental treatment to be provided will require the patient to follow the post- operative and post- care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understood this consent, and that all questions above the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.  
I understand that this consent form will remain in effect until the time that I choose to terminate it.

Patient Name \_\_\_\_\_

Reviewed With Team Member \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_

Date \_\_\_\_\_



**Dr. Peter E. Ciampi & Associates**  
**310 Morris Avenue**  
**Spring Lake, NJ 07762**  
**732-449-5666**

**CONSENT TO EMERGENCY TREATMENT**

-----  
Patient's name

I have been informed by Dr. Peter Ciampi and or Associates of the need to undergo dental treatment as prescribed to me at this time.

I understand that today's treatment is only to address my emergency needs and that successful treatment depends on my return for a follow up visit, which will include a full examination.

I have been fully informed about the details of the recommended treatment and alternatives, risks and benefits. I agree to accept the proposed treatment as recommended by Dr. Peter Ciampi and or Associates.

I understand that individual reactions to treatment cannot be predicted, and if I have any unanticipated reaction during or following any treatment, I will report them to the office immediately.

I have been advised that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following oral hygiene and dietary instructions at home, and reporting any changes in my health status to the office as soon as possible.

I have been informed that antibiotics can decrease the effectiveness of oral contraceptives.

I have been advised, that long-term results of untreated gum disease will lead to the loss of teeth which can be painful and disfiguring.

I have discussed the above with Dr. Ciampi and have had all my questions answered.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

X \_\_\_\_\_  
Signature of patient (or parent or guardian if minor)

Date \_\_\_\_\_



DR. PETER CIAMPI AND ASSOCIATES  
310 Morris Avenue  
Spring Lake, NJ 07762

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign this Acknowledgment\*\***

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

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
Date)

---

For Office Use Only

---

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

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



### **COVID-19 Dental Treatment Consent Form**

I, \_\_\_\_\_, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing. Dental procedures create water spray which is how the disease is spread. The ultra-fine natural of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

1. I confirm I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever or chills
- New loss of taste or smell
- Flu like symptoms

2. Have you been fully vaccinated against COVID-19?

Yes

No

Prefer not to answer

3. Are you self-inoculated from having COVID-19?

Yes

No

Prefer not to answer

Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_