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
- Liver Disease
- Heart Trouble
- Venereal Disease
- Pacemaker
- Anemia
- Thyroid
- Heart Murmur
- Kidney Disease,
- Epilepsy
- Hepatitis
- 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 COMMUNICATIONSS & 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 PLAM. 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 accompanies 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_____ **Signature of Patient or Guardian**_____
Reviewed With Team Member_____ **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 out 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)

_____
_____
_____

Spring Lake Dental Care

Early Detection with a painless Exam is Your Best Protection

Patient Consent Form-Oral Cancer Screening

Oral cancer rates are on the rise and the seriousness of this disease cannot be overestimated. To address and reduce the incidence of oral cancer, our practice has instituted a voluntary oral cancer screening in line with our policy of providing the most advanced dental care available to our patients.

People at risk are those who use tobacco and alcohol, as well as anyone over 40 years of age. However, statistics show that over 25% of oral cancer victims do not exhibit any of
These risk factors and this year alone over 30,000 Americans will die of oral cancer. As with any cancer early detection is the most critical factor in defeating this disease

Our practice recently incorporated the Velscope into our oral screening standard of care.
We find that using the Velscope along with a visual oral cancer examination improves the ability to identify a suspicious area at its earliest stages. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The exam will be offered to you annually.

The enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however this exam might not be covered by your insurance. The fee for this enhanced examination is $75.00

Yes. I authorize the clinician to perform the Velscope exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination

Print Name: _____

Signature: _____Date_____

No. I would prefer not to have the Velscope exam at this time.

Print Name: _____

Signature: _____Date_____

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: _____