Thomas R. Lambert, DMD, MAGD
2299 Brodhead Rd, Suite E
Bethlehem, PA 18020
(610) 868-9928

Comprehensive New Patient Form

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.

Today's Date: _____

Please tell us about yourself

Patient's Name: _____ I prefer to be called: _____

Please check one: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Preferred method of contact: (please check) ☐ 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 #: _____

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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: _____

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Emergency Contact Information

Name of Person to Notify In Case of Emergency: _____

Relationship: _____ **Home Phone #:** _____

Work #: _____ **Cell #:** _____

Consent

The undersigned hereby authorizes 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 (Guardian if Minor): _____ **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:

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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?

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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

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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** _____

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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

   If 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 check)

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 Novocain	☐ Yes	☐ No

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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 check):

   ☐ 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

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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

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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
- ☐ Excessively receded
- ☐ Reddened
- ☐ Crowns are ill-fitting or darkened edges
- ☐ Bleed easily
- ☐ 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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HIPAA 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: _____