MAVROMATISDENTAL
A Division of Atlantic Dental Care, PLC

New Patient Registration

Patient Info

The patient is a/an:
- ○ Adult
- ○ Child
- ○ Adult under Guardianship

Gender
- ○ Male
- ○ Female
- ○ Prefer Not To Say

Title
- ○ Dr.
- ○ Mr.
- ○ Mrs.
- ○ Ms.

Patient's First Name _____

Patient's Middle Name _____

Patient's Last Name _____

Preferred Name (if different) _____

Date of Birth _____

Street Address _____

Apt/Suite/Unit # _____

City _____

State _____

Zip Code _____

Home Phone _____

Cell Phone _____

Email _____

Occupation _____

Employer _____

Work Phone _____

Martial Status
- ○ Single
- ○ Married
- ○ Divorced
- ○ Seperated
- ○ Widow

Preferred method of contact?
- ○ Phone Call
- ○ Text
- ○ Email

Who can we thank for referring you to our office? _____

What is your preferred Pharmacy? _____

Guardian's Info (If patient is a minor)

Full Name _____

Relationship to the Patient _____

Phone Number _____

Email _____

Emergency Contact

In case of medical emergencies and we need to inform someone about your condition, please give us the contact information that is is able to help you. Guardian, please put information that is different from yours. Someone who is able to assist when you are not available, or someone who can get a hold of you in case of an emergency.

Full Name _____

Relationship to the Patient _____

Phone Number _____

Email _____

Insurance

Do you have Dental Insurance?
- ○ Yes
- ○ No

Primary Insurance Company _____

Primary Insurance ID Number _____

Primary Insurance Group Name or Number _____

Primary Subscriber Name & Date of Birth: _____

Secondary Insurance Company _____

Secondary Insurance Number/ID _____

Secondary Insurance Group Name or Number _____

Secondary Subscriber Name & Date of Birth _____

Dental History

Please check YES/NO to each question. If you're unsure how to answer, please consult our staff!

Reason for today's visit? _____

Who is your previous dentist? _____

Date of your last dental visit?

Last dental cleaning?

Last dental x-ray?

Do we have permission to request your records?

- ○ Yes
- ○ No

Are you happy with your smile?

- ○ Yes
- ○ No

Do you have dental anxiety or white coat phobia? If yes, please explain below?

Have you ever had any of the following?

- ☐ Periodontal Treatment (treatment of gums)
- ☐ Your bite adjusted or teeth ground
- ☐ Orthodontic Treatment (to straighten or realign teeth)
- ☐ Oral Surgery (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints)
- ☐ Implants
- ☐ NONE

Do you feel you have bad breath?

- ○ Yes
- ○ No

How often do you brush your teeth?

Do your gums bleed when brushing or eating, or do you suffer from pain or swelling of your gums? Please explain.

Are any of your teeth sensitive to heat, cold, sweets, or pressure?

Do you use tobacco products (including cigarettes, cigars, dip, or vape pens)?

Have you ever experienced any of the following jaw problems?

- ☐ Popping/clicking in your jaw joints
- ☐ Pain when teeth are clenched
- ☐ Pain in your jaw joints, around your ear, or side of your face
- ☐ Pain or difficulty when chewing
- ☐ Difficulty in opening or closing
- ☐ NONE

Do you have any of the following habits?

- ☐ Clenching or grinding your teeth while awake or asleep
- ☐ Placing foreign objects in your mouth (pencils, fingernails, pens)
- ☐ Biting your cheeks or lips
- ☐ Mouth breathing while awake or asleep
- ☐ NONE

Medical History

Who is your primary care physician?

Are you being treated for any medical condition at present or within the past years? If yes, please explain.

Has there been any changes in your general health in the past year?

List any PRESCRIPTION or NON-PRESCRIPTION drugs you are taking or have recently taken (including birth control pills and vitamins):

Have you ever had any adverse or unusual reactions to any medications or injections? (e.g. penicillin or other antibiotics, aspirin, codeine, local anesthetic?

Have you ever been advised against taking any specific type of medication?

Do you have any DRUG allergies?

Do you have any other allergies (e.g. hay fever, food allergies, latex/rubber, iodine or metal allergies)?

Have you ever fainted during dental or medical treatment or experienced vertigo?

- ○ Yes
- ○ No

Do you take or have you taken any kind of bone density (bisphosphonate) medications such as Fosamax, Actonel, or Boniva?

Do you bleed excessively from a cut, bruise easily, or have any blood disorders?

Do you have any artificial joints (e.g. hip, knee)?

- ○ Yes
- ○ No

Have you ever been advised by a medical doctor to take pre-medication/antibiotics before dental treatment?

Indicate which of the following you presently have, or ever had: (Please check all that apply)

- ☐ Asthma
- ☐ Glandular Disorders (Sjögren's syndrome)
- ☐ Diabetes
- ☐ Jaundice
- ☐ Lung Disease
- ☐ Ulcers
- ☐ Epilepsy or Seizures
- ☐ Bronchitis
- ☐ Organ Transplant/Medical Implant

Is there anything else about your health we should be made aware of; or do you wish to speak to the doctor privately about any problem or medical condition?

- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Emphysema
- ☐ Stomach/Intestinal Problems
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ HIV/Aids
- ☐ Immune Disorders (Rheumatoid / Lupus)
- ☐ Arthritis
- ☐ NONE

WOMEN ONLY: Are you pregnant? If so, when is your delivery date?

Signature:

Sign

Financial Policy

•FULL PAYMENT IS DUE AT TIME OF SERVICE. •WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.

Insurance: Coverage and Co-pays

We provide insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by our team regarding his/her remaining benefit in any such benefit period. For covered services, all co-pays and deductibles must be paid on the day of treatment. Since your insurance company may not cover all costs, we require that you pay any percentage of your balance not paid by your insurance on the day of treatment. For services that are not covered by your insurance, we require that you pay the entire fee the day of your treatment We will attempt to answer any questions we can about your insurance and, to the extent practicable, assist you with insurance billing issues. However, your insurance contract is an agreement between you and your insurance carrier to which we are not a party. In the event that your insurance company does not pay any amounts due for your care, you agree you are financially responsible for such amounts, and that you will pay such amounts due for your care.

Patients Without Insurance

For patients without insurance coverage, you will be responsible for payment on the day of treatment. If you are not able to pay in full, or if your treatment requires several visits, you will be issued an invoice and will be able to discuss payment arrangements with a member of our business office staff.

Cancellation/No Show Policy

Our office requires at least 24 hours advance notice to cancel your appointment in the case of an emergency. *We reserve the right to charge a reasonable fee, up to the amount normally due for our services, for patients who do not give advance notice to cancel an appointment.

Collections

A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on your account including all attorneys' fees, interest, and late fees.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature:

Sign

Your Information. Your Rights. Our Responsibilities.

Notice of Privacy Practices (HIPAA)

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to: • Prevent or control disease, injury or disability; • Report child abuse or neglect; • Report reactions to medications or problems with products or devices; • Notify a person of a recall, repair, or replacement of products or devices; • Notify a person who may have been exposed to a disease or condition; or • Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts. Required by Law. We may use or disclose your health information when we are required to do so by law.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker’s Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs established by law.

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 the protected health information of an inmate or patient.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

SUD Treatment Information

If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Signature of Patient, Parent, Guardian or Personal Representative:

Sign

HIPAA Acknowledgement & Consent For Communication

HIPAA Compliance Patient Consent Form - Our Notice Of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that: · Protected health information may be disclosed or used for treatment, payment or healthcare operations. · The practice reserves the right to change the privacy policy as allowed by law. · The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions. · The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. · The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments?

- ○ Yes
- ○ No

May we leave a message on your answering machine at home or on your cell phone?

- ○ Yes
- ○ No

May we discuss your dental conditions, appointments or billing questions with any member of your family?

- ○ Yes
- ○ No

If YES, please name the family members allowed and their relationship to you:

Signature

Sign