

# MEDICAL HISTORY

## SMILES 😊 UNLIMITED

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When was your last dental exam? \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason for appointment: \_\_\_\_\_ How did you hear about \_\_\_\_\_

### Patient Information

Patients Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ M \_\_\_\_ F \_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

Home #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_ Business #: \_\_\_\_\_

Email Address: \_\_\_\_\_  
(This will be used for appointment reminders and to advise when work is needed)

Social Security #: \_\_\_\_\_ Drivers license #: \_\_\_\_\_

Are you a full Time Student? (Between the ages of 18-25) YES / NO

Name & Location of School: \_\_\_\_\_

### Spouse/Parent or Guardian Information (If patient is under age please fill out portion below)

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ M \_\_\_\_ F \_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_  
(Street Address) If Different from above (City) (State) (Zip Code)

Home #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_ Business \_\_\_\_\_

Social Security #: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

### EMERGENCY CONTACT INFO:

Name to contact in case of emergency: \_\_\_\_\_

Phone # of contact: \_\_\_\_\_ Relationship of contact: \_\_\_\_\_

\*\*Please note if you are unable to attend your appointment we request that you notify our office **48 hours** in advance to cancel. If cancellation is on the day of your scheduled appointment there will be a fee of **\$150.00** charged to you. Please sign below stating that you understand and are aware of this agreement.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_

## **Insurance Information**

### **\*DENTAL – Primary Insurance Carrier:**

Name of INS Company: \_\_\_\_\_

Employee's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

ID# on Card: \_\_\_\_\_ Group#: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Ins Phone #: \_\_\_\_\_

Work Company Name & Address of Employer: \_\_\_\_\_

### **Occupation Information**

Name of Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Phone#: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

### **\*DENTAL – Secondary Insurance Carrier:**

Name of INS Company: \_\_\_\_\_

Employee's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

ID# on Card: \_\_\_\_\_ Group#: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Ins Phone #: \_\_\_\_\_

Work Company Name & Address of Employer: \_\_\_\_\_

### **Occupation Information**

Name of Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Phone#: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

Print Name: \_\_\_\_\_

## Medical Information

**Allergies:** Check the areas that apply to you

\_\_\_\_ Seasonal      \_\_\_\_ Latex      \_\_\_\_ Keflex      \_\_\_\_ Penicillin      \_\_\_\_ Sulfur  
\_\_\_\_ Iodine      \_\_\_\_ Aspirin      \_\_\_\_ Epinephrine      \_\_\_\_ Local Anesthetic      \_\_\_\_ Codeine  
\_\_\_\_ Milk      \_\_\_\_ Other: Please Specify: \_\_\_\_\_

**IF NONE APPLY, PLEASE CHECK HERE:** \_\_\_\_\_

**Medical Alerts:** check the areas that apply to you: **IF NONE APPLY, PLEASE CHECK HERE:** \_\_\_\_\_

\_\_\_\_ Rheumatic Fever      \_\_\_\_ Thyroid Problems      \_\_\_\_ Tuberculosis  
\_\_\_\_ Heart Murmur      \_\_\_\_ Lung Problems/asthma      \_\_\_\_ Herpes  
\_\_\_\_ Mitral Valve Prolapse      \_\_\_\_ Ulcer or Stomach Problems      \_\_\_\_ Pacemaker  
\_\_\_\_ Hepatitis/Liver disease      \_\_\_\_ HIV/AIDS      \_\_\_\_ Open Heart Surgery  
\_\_\_\_ Heart Valve Replacement      \_\_\_\_ Epilepsy      \_\_\_\_ High Blood Pressure  
\_\_\_\_ Bleeding/clotting Disorder      \_\_\_\_ Nervous Disorder      \_\_\_\_ Arthritis  
\_\_\_\_ Diabetes      \_\_\_\_ Hip/Joint Replacement  
\_\_\_\_ Any Other Illness Specify: \_\_\_\_\_

Are there any illnesses or disease that runs in your family? (Diabetes, heart conditions, cancer, ect...) Please list below:

\_\_\_\_\_

Do you currently smoke? No \_\_\_\_ Yes \_\_\_\_ If yes, how many a day/week: \_\_\_\_\_

If yes, are you interested in quitting? No \_\_\_\_ Yes \_\_\_\_ Someday \_\_\_\_ Not sure \_\_\_\_ Have tried in Past \_\_\_\_

Are you currently under the care of a physician? .....▶ \_\_\_\_ No \_\_\_\_ Yes

If yes, reason: \_\_\_\_\_

**When was your last physical exam?** \_\_\_\_\_

Are you presently taking any medications? .....▶ \_\_\_\_ No \_\_\_\_ Yes

If Yes, Please List: \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_ No \_\_\_\_ Yes      If yes, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for hospitalization: \_\_\_\_\_

Have you had X-ray treatments or Chemotherapy: .....▶ \_\_\_\_ No \_\_\_\_ Yes

Do any wounds heal slowly or present complications? .....▶ \_\_\_\_ No \_\_\_\_ Yes

**Name and Phone Number of your Physician:** \_\_\_\_\_

**Pharmacy Name and Number:** \_\_\_\_\_

Women:

Are you presently taking birth control: .....▶ \_\_\_\_ No \_\_\_\_ Yes

Are you pregnant or is there a chance you might be? .....▶ \_\_\_\_ No \_\_\_\_ Yes

**RICHARD M. RICHMAN D.D.S, P.C.**  
**PRIVACY PRACTICES AUTHORIZATION**

**Acknowledgement of Receipt of Privacy Practices**

I acknowledge that I was provided a copy of Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and understood the notice. I understand that I may revoke the authorizations at any time by writing to the Privacy Officer listed in the Notice of Privacy Practices.

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Patient Name (please print)

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Date

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Parent or Authorized Representative (if applicable)

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Signature



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www.smilesunlimited.com

**SIGNATURE ON FILE AUTHORIZATION**

I hereby authorize Richard M. Richman to use my signature on file to process claims and secure payments from my insurance company for dental services provided on my behalf.

Patient Name (please print) \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature