

MEDICAL HISTORY SMILES 😊 UNLIMITED INC.

Richard M. Richman, D.D.S, P.C.
165 North Village Avenue, Suite 12
Rockville Centre, N.Y. 11570
Phone: (516) 594-2111 Fax: (516) 594-2581

When was your last dental exam? _____

Today's Date: _____

Reason for appointment: _____

How did you hear about us? _____

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 #: _____

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: _____

Occupation Information

Name of Employer: _____ Occupation: _____

Employer Phone#: _____ No. Years Employed: _____

Employer Address: _____
(Street Address) (City) (State) (Zip Code)

Insurance Information

***Primary Insurance Carrier**

Employee's Name: _____ DOB: _____ Name of Employer: _____

Employer Address: _____ Phone #: _____

ID#: _____ Name of Insurance: _____ Ins Phone: _____ Group#: _____

***Secondary Insurance Carrier**

Employee's Name: _____ DOB: _____ Name of Company: _____

Company Address: _____ Phone #: _____

ID#: _____ Name of Insurance: _____

Group#: _____ Insurance Phone#: _____

Medical Information

Allergies: *Check the areas that apply to you* **IF NONE APPLY, PLEASE CHECK HERE:** _____

Seasonal Amoxicillin Keflex Penicillin Sulfur
 Iodine Aspirin Epinephrine Local Anesthetic Codeine
 Milk Other: Please Specify: _____

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

Rheumatic Fever Thyroid Problems Tuberculosis
 Heart Murmur Lung Problems Herpes
 Mitral Valve Prolapse Ulcer or Stomach Problems Venereal
 Pacemaker Hepatitis AIDS
 Open Heart Surgery Jaundice A. R. C.
 Heart Valve Replacement Epilepsy HIV
 Bleeding Disorder Nervous Disorder High Blood Pressure
 Clotting Disorder Arthritis Low Blood Pressure
 Asthma Diabetes Hip Replacement
 Liver Problems Joint Replacement
 Any Other Illness Specify: _____

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 taken or are you currently taken any of the following medications? (circle) Fosamax, Actonel, Boniva, Dirdronel

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

****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 **\$75.00** charged to you. If you are seeing a specialist in our office the cancellation fee will be **\$150.00**. Please sign below stating that you understand and are aware of this agreement.**

Signature _____ **Date** _____

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.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature

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www.smilesunlimited.com

TO ALL PATIENTS: PLEASE BE AWARE!!!

(Especially Delta Dental and Healthplex Patients)

There are some Insurance companies that will mail payments to you rather than our office. If you receive a payment from your insurance company, **please sign the back of the check and mail it, along with the EOB (statement that comes with it), to our office at the address above.** If our office has not received the check within two weeks, you are responsible to pay the office fees in full.

Please sign below that you have read the above and understand that any checks you receive need to be returned to our office.

Thank you for your cooperation.

Richard M. Richman D.D.S, P.C.



Please print name

date

Please sign name

date

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SIGNATURE ON FILE AUTHORIZATION

I hereby authorize Dr. Richard M. Richman and Smiles Unlimited Inc. 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