Smiles Unlimited

214 Maple Avenue 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 #: _____

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: _____

Occupation Information

Name of Employer: _____ Occupation: _____

Employer Phone#: _____ No. Years Employed: _____

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

Insurance Information

***Primary Insurance Carrier:**

Name of INS Company: _____ Employee's Name: _____
D.O.B:_____ID#: _____ Group#:_____
Effective Date: _____Ins Phone #: _____
Work Company Name & Address: _____

***Secondary Insurance Carrier:**

Name of Ins Company: _____ Employee's Name: _____
D.O.B:_____ID#: _____ Group#:_____
Effective Date: _____Ins Phone #: _____
Work Company Name & Address: _____

Medical Information

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

_____Seasonal _____Latex _____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
_____ Heart Murmur
_____ Mitral Valve Prolapse
_____ Pacemaker
_____ Open Heart Surgery
_____ Heart Valve Replacement
_____ Bleeding Disorder
_____ Clotting Disorder
_____ Asthma
_____ Liver Problems
_____ Thyroid Problems
_____ Lung Problems
_____ Ulcer or Stomach Problems
_____ Hepatitis
_____ Jaundice
_____ Epilepsy
_____ Nervous Disorder
_____ Arthritis
_____ Diabetes
_____ Joint Replacement
_____ Tuberculosis
_____ Herpes
_____ Venereal
_____AIDS
_____ A. R. C.
_____HIV
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Hip 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_____

Smiles Unlimited

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

Hipaa privacy notice 031203

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Payment for Services Agreement

It is understood that I, _____ the Patient (or guardian of the Patient in the event the Patient is under the age of 18) am personally responsible for the timely payment for the dental services performed by Dr. Richard M Richman, D.D.S. as well as any other doctors associated with Smiles Unlimited Dentistry, P.C.

I understand that some insurance companies reimburse for dental services by writing a check directly to the Patient. I understand these are not my funds, and I, the Patient need to pay this reimbursement check to the Dentist. So if I receive a payment directly, I the patient, (or guardian of the patient in the event the patient is under the age of 18) understand that I must sign the back of the check and endorse it by writing "Payable to Smiles Unlimited Dentistry, P.C.", and then deliver it to Smiles Unlimited Dentistry, P.C. no later than 48 hours after receipt, by hand or mail to:

Smiles Unlimited Dentistry, P.C.
214 Maple Avenue
Rockville Centre, NY 11570

I understand that Smiles Unlimited Dentistry, P.C. will impose interest at 1% per month from the date the insurance check is paid to the patient in the event the check is not endorsed as described.

In the event of non-payment, Patient is responsible for all costs and legal fees associated with collection of the debt, calculated as 20% of the amount owed, not including interest.

In the event of non-payment, I authorize a credit check to be performed on me by a credit agency, and agree to the terms of Section 604 of the Fair Credit Reporting Act that this credit report is being sought for a permissible purpose. The credit information will be used to settle any debt, and will otherwise be kept confidential.

_____ _____

Patient Name Patient Signature

_____

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

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AUTHORIZATION

I/we grant authority to the Dentist to perform procedures and treatments, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary.

I/we hereby authorize release of any information relating to dental treatment and dental claims. I/we agree to be responsible for payment of services not covered by insurance.

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Responsible Party's Signature Date

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Credit Card Authorization

It is the practice policy of Smiles Unlimited Dentistry, P.C. to maintain a credit card on file for every patient to process any remaining outstanding charges you may have after your insurance company has processed your claim. This information will be held securely until your insurance carrier has paid its portion and notified us of your share. After we have received notice from your insurance company, we will charge any remaining balance to your credit card. We will mail or email you a receipt for the charge. Please note that this process will not compromise your ability to dispute a charge with your insurance carrier's determination of payment.

I_____ Authorize Smiles Unlimited Dentistry to charge outstanding balances to the following credit card.

Credit Card Information

Credit Card Type: _____ Account Number: _____

Security Code: _____ Expiration Date: _____

Billing Address: _____

Name on Card: _____ Signature: _____