

Richmond Dental Arts, PC
808 Annadale Road
Staten Island, NY 10312



Date _____

Social Security Number _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Cell Phone _____ Work Phone _____ Email Address _____

Whom May We Thank for Referring You?

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party:

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Cell Phone _____

Employer _____ SSN # _____ Birthdate _____

Is this person currently a patient in our office? _____

Insurance Information

Primary Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SSN# _____

Employer _____

Occupation _____

Insurance Company _____

Group # _____ ID # _____

Ins. Co. Address _____

City, State, Zip _____

Secondary Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SSN# _____

Employer _____

Occupation _____

Insurance Company _____

Group # _____ ID # _____

Ins. Co. Address _____

City, State, Zip _____

Preferred Pharmacy

Pharmacy Name _____ Phone # _____

Address _____

Patient Name: _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? Yes No

7. Are you ALLERGIC to or have you had any reactions to:

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No

Local Anesthetics (e.g. Novocain) Yes No

If yes, please explain _____

Penicillin or any other Antibiotics Yes No

Sulfa Drugs Yes No

Barbiturates Yes No

3. Are you taking any medication(s) including nonprescription medicine? Yes No

Sedatives Yes No

If yes, what medication(s) are you taking? _____

Iodine Yes No

Aspirin Yes No

Any Metals (e.g. , nickel, mercury. etc. Yes No

Latex Rubber Yes No

Other (please list) _____

4. Are you using tobacco products? Yes No

If yes, Check all that apply: Cigarettes Cigars

Chewing Other

5. Do you use controlled substances? Yes No

8. Women Only:

a) Are you pregnant or think you may be? Yes No

b) Are you nursing? Yes No

c) Are you taking oral contraceptives? Yes No

6. Do you have or have you had any of the following? High Blood Pressure Yes No Heart Disease Yes No

Immune System Disorders Yes No

Heart Attack Yes No

Cardiac Pacemaker/Stent Yes No

Stroke Yes No

Rheumatic Fever Yes No

Heart Murmur Yes No

Hay Fever/Allergies Yes No

Fainting/Seizures Yes No

Tuberculosis Yes No

Low Blood Pressure Yes No

Anemia Yes No

Radiation Therapy Yes No

Cancer Yes No

Emphysema Yes No

Epilepsy/Convulsions Yes No

Arthritis Yes No

Leukemia Yes No

Asthma Yes No

Osteoporosis Yes No

Liver Disease Yes No

Diabetes Yes No

Joint Replacement Yes No

Heart Trouble Yes No

Kidney Diseases Yes No

Hepatitis / Jaundice Yes No

Respiratory Problems Yes No

Sexually Transmitted Disease Yes No

Mitral Valve Prolapse Yes No

Thyroid Problem Yes No

Stomach Troubles/Ulcers Yes No

Other Yes No

Are you currently taking any blood thinner medication ex Plavix, Coumadin, Eliquis or other _____

Are you currently undergoing chemotherapy? If yes, how often. _____

Are you currently taking any Bisphosphonates? _____

Patient Dental History

When was your last dental check-up? _____ What was done at that time? _____

1. Do you bleed while brushing or flossing? Yes No

5. Have you had any head, neck or jaw injuries? Yes No

2. Are your teeth sensitive to hot or cold liquids/food? Yes No

6. Have you ever had prolonged bleeding following extractions, surgery or trauma? Yes No

3. Are your teeth sensitive to sweet or sour liquids/food? Yes No

4. Do you feel pain in any of your teeth? Yes No

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health. I understand that providing incorrect information can be dangerous to my health.

Furthermore, I agree that I will be responsible for any kinds of fees incurred for my dental services.

Payment is due in full at time of treatment unless prior arrangements have been made.

Signature of patient, parent, guardian or personal representative _____ Date: _____



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**AUTHORIZATION FOR SIGNATURE ON FILE
RELEASE OF INFORMATION/FINANCIAL RESPONSIBILITY
AND AUTHORATION OF PAYMENT**

I, _____ (PATIENT'S NAME) hereby authorize the office of Richmond Dental Arts, PC to add my name to any and all claims or documents as related to any and all health benefits due to me and my dependents through my insurance coverage with _____ (INSURANCE COMPANY NAME).

I hereby authorize payment of dental benefits otherwise payable to me, directly to Richmond Dental Arts, PC. I have reviewed the treatment plan fees given to me by my insurance company. I agree to be responsible for all charges of dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contracted agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to my dental plan.

I understand that it is my responsibility to inform Richmond Dental Arts, PC if there are any changes to my dental insurance that may affect any and all dental visits. I also understand that any and all payments due from me as the patient are to be made in full on the day that my treatment is completed.

This authorization will be valid from the date signed below. A photo copy of this documentation may act as an original.

Signature of Patient (or Guardian of minor) _____ Date _____

Richmond Dental Arts, PC
808 Annadale Road
Staten Island, NY 10312



Patient Name _____

Date: _____

ACKNOWLEDGEMENT AND CONSENT FORM

I understand that Richmond Dental Arts, PC will use and disclose health information about me.

I understand that my health information may include both created and received by that practice, may be in the form of written or electronic records, or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar of health-related information.

I understand and agree that Richmond Dental Arts, PS may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage and submit bills, claims and other related information to insurance companies or other who may be responsible to pay for some or all of my health care and
- Perform various offices, administrative and business functions that support my physician's efforts to provide me with arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Richmond Dental Arts, PC will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures oh health information made and the information practices followed by the employees, staff and other office personnel or Richmond Dental Arts, PC and my rights regarding, my health information.

I understand that theNotice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Privacy Practice.

I understand that I have the right to ask that some o all of my health information may not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that this practice is not required by law to agree to such request.

By signing below, I agree that I have reviewed and understand the information above

Patient Signature _____

Date _____

Richmond Dental Arts

Patients Name: _____ Date Of Birth: _____

Office policy

Patients without Dental Insurance:

- Payment is expected at the time services are rendered.

Patients with Dental Insurance

- Your insurance policy is an agreement between you and your insurance company. If insurance does not pay for any services received from our office, you are responsible for the balance.
- All insurance co-pays and deductibles must be paid at the time of service.
- For your convenience we accept: Cash, Check, Credit Card, Apple pay OR care credit.
- A returned check fee of \$30 will be added to your account for any returned check.
- Delinquent balances over 90 days will be referred to an outside collections agency. Accounts referred to collections will be charged 25% of the balance.
- I understand although I have given my dental insurance, insurance is not a guarantee of benefits and I am responsible for my bill and any unpaid insurance claims.

Cancellation policy

- We understand appointments will have to be rescheduled from time to time due to personal or family emergencies: however, we value your time at Dr. Sandler's and we ask that you please do the same for us.
- If you find you must change your appointment, require a minimum of 24 hour notice.
- If proper notice is not received a \$25 cancellation/ missed appointment fee will be charged.

Signature: _____ Date: _____