Louis A. Riccardi D.D.S., P.C.

N. Alexandra Riccardi D.M.D.

WELCOME and we appreciate you choosing our office for your dental needs. The following information will be held in compliance with the applicable HIPAA laws.

PATIENT INFORMATION

Patient's Name_____(◯M◯F) ◯Married◯Single◯Divorced◯Widowed

Birth Date_____Social Security # _____

E-mail Address_____ Cell Phone _____

Home Address_____Apt # _____

City_____State_____Zip _____

Home Phone_____Dental Insurance (◯Y◯N)

Spouse's Name_____Contact # _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

(if different than patient)

Last Name_____First_____MI _____

Birth Date_____Social Security # _____

Relationship to Patient_____Work Phone _____

Employer_____

Employer Address _____

City_____State_____Zip _____

Home Address_____Apt # _____

City_____State_____Zip_____

Home Phone_____Cell Phone _____

EMERGENCY/CONSENT TO INFORMATION

I understand that by signing this consent form I am allowing my medical information to be released in the event of an emergency or upon request by:

Closest relation not living with you,_____Phone_____

Address_____City_____State_____Zip _____

PATIENT / GUARDIAN SIGNATURE_____Date _____

CHILDREN ACCOUNTS

If the patient is under 18 years old, please complete the following. Please be aware that the parent/guardian of the minor patient is responsible for the account.

Parent/Guardian_____Minor's Relationship _____

Date of Birth_____Social Security # _____

Home Phone_____Cell Phone _____
Email Address _____

Employer_____Work Phone _____
Employer Address _____
City_____State_____Zip _____
I authorize the dental staff to perform the necessary dental services my child may need:

_____ _____
Signature of Parent or Guardian Date

DENTAL INSURANCE INFORMATION & ASSIGNMENT OF BENEFITS

Primary Insured _____

Employer_____

Birth Date_____Social Security # _____

Group #_____ID # _____

Insurance Carrier_____Effective Date _____

Insurance Carrier's Phone # _____

Claims Address _____
City_____State_____Zip _____
Others Covered _____
Secondary carrier/dental insurance plan?_____/Carrier _____

We accept the assignment of your insurance benefits directly to our office subject to verification of coverage. We make **best estimate** patient portion benefits based on the information provided by your carrier, but **we are unable to guarantee your insurance coverage**. All treatment coverage is subject to carrier review. **However, our office will make best efforts on your behalf to receive proper benefits**. Our insurance Coordinator will be happy to provide best estimate coverage before your initial treatment.

I understand the practice's policy, and assign directly to Louis A. Riccardi, D.D.S.,P.C., all benefits that would be payable to me for dental services rendered. I hereby authorize this office to use this signature on all of my insurance submissions and allow the release of any information necessary to secure the payment of benefits. I understand that I am responsible for any amounts not paid by my insurance company within 60 days. Any payments received directly by me from my insurance carrier for dental services I agree to notify and deliver to Louis A. Riccardi, D.D.S.,P.C., within 10 days of receipt.

PATIENT / GUARDIAN SIGNATURE_____Date _____

FINANCIAL INFORMATION

Thank you for choosing our office for your dental needs. Professional services are rendered and charged to the responsible party. We will be happy to work with you in planning treatment to fit your financial needs. We reserve the right to ask that you pay in full for treatment on the day that services are performed. If you should need extensive dental treatment, we gladly offer extended payment plans, but arrangements must be made with our Financial Coordinator prior to treatment. For your convenience, we accept cash, checks ($30.00 fee for returned checks), and VISA/MasterCard/AMEX/Discover as payment. Please note that a 1.5% service charge will be applied to accounts over 90 days old.

For our patients who have dental insurance, your estimated portion will be due on the day of treatment, and we **never guarantee** an exact amount that your insurance carrier will pay. You will be responsible for any remaining amount not covered by your insurance carrier including: deductibles, co-payments, services or charges denied by the carrier, or amounts over your carrier's allowances. The amounts you are charged or reimbursed are subject to change at the discretion of your insurance company and do not affect the amount due for services rendered. Also, we reserve the right to request and you agree to pay any claim not processed by your insurance company within 60 days. As a courtesy to you we try to give you notice after your amount due is outstanding for 45 days.

Please sign below that you have read and understand the above financial procedures and agree to all of the terms. If you have any questions please speak to our office manager prior to your appointment.

PATIENT/ GUARDIAN SIGNATURE_____Date _____

EXTENDED PAYMENT

A third-party organization such as Care Credit is available to provide financing to patients for dental treatment. A patient must qualify for this type of arrangement. Applications are available in this office. Please feel free to ask for one.

YOUR PRIVACY

Your privacy is assured in our office and your health records require your written consent to be released. Along with your forms you have been afforded access to our Privacy Policies as required by the HIPAA Privacy Act (proposed by the US Department of Health and Human Services-effective April 1, 2003). Please sign this so we know you have received a copy of our privacy practices.

PATIENT/ GUARDIAN SIGNATURE_____Date _____

PHOTOGRAPHY RELEASE

I authorize the office of Louis A. Riccardi, D.D.S.,P.C., to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that if any of these are used in any educational purposes, as a part of a demonstration, or advertisement, my name or any other identifiable information will be kept confidential. I do not expect compensation, financial or otherwise for the use of these photographs.

PATIENT/ GUARDIAN SIGNATURE_____Date _____

BROKEN APPOINTMENT POLICY

Please consider your scheduled appointments carefully. We ask for at least a 24-hour notice of cancellation. If we do not receive a 24-hour cancellation notice, we will charge you $35.00 for the scheduled time after the 3rd cancelled appointment. We are here for you and allocate our staff and office resources to serve you. If you cancel without proper notice, we know you understand that we may not be able to fill your appointment with another patient, and we are still responsible for the staff and office resource costs incurred. This cannot be charged to your insurance company. If you repeatedly miss scheduled appointments, you may be asked to pursue treatment on non-scheduled time, as available.

PATIENT/ GUARDIAN SIGNATURE_____Date _____

PATIENT MEDICAL HISTORY

PATIENT'S NAME:_____DATE_____

In our office you are the reason we are here. We would like to give you dental care designed to your individual needs and ask that you aid us in answering the following questions as completely as possible. Your records are held in strict confidence, and will not be released to anyone without your written consent.

Do you require premedication with antibiotics before dental treatments? ◯ Y ◯ N

For what condition? _____

DENTAL HISTORY

Reason for initial visit_____

Date of last dental visit_____ Last cleaning_____ Last x-rays _____

Former dentist_____ Phone number_____

Is there anything that concerns you about your mouth/gums/teeth/smile?_____

_____

How often do you brush/day_____ floss_____

Do you have any of the following oral health issues:

Bad Breath	Y	Wisdom teeth removed	Y
Clicking /popping of jaw	Y	Periodontal treatment / Gum treatment	Y
Bleeding / sore gums	Y	Blisters / canker sores	Y
Sensitivity to hot / cold	Y	Sensitivity when biting	Y
Loose teeth	Y	Orthodontic treatment	Y
Sensitivity to sweets	Y	Discolorations in mouth	Y
Dry mouth	Y	Grinding / Clenching of teeth	Y
Jaw surgery / Tooth removal	Y	Dental implants	Y

MEDICAL HISTORY

Name of family physician:_____ **Phone #**_____

Date of last visit with physician:_____

DRUG ALLERGIES

Codiene	Y	Nitrous oxide (laughing gas)	Y
Barbituates	Y	Penicillin	Y
Dental anesthetic (novacaine, xylocaine, mepivacaine)	Y	Sulfa drugs	Y
Latex	Y	Aspirin	Y
Erythromycin	Y	Others	

MEDICATIONS

Please list any prescription or nonprescription medication you currently take (or are supposed to be taking), dosage, and for what condition. If you have an extensive list of medications, we ask you to please bring it with you so that we may make a copy.

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____

Have you taken Cortisone or any other steroids in the past 12 months? _____

Recreational drugs can also interfere with your dental health and anesthetics we may use during your treatment. Please inform us before treatment if any have been used within a week of your appointments. Any information is held as a part of the Doctor/Patient confidentiality relationship.

Do you have or have you had any of the following;

Heart Disease / failure /attack	Y	Stomach problems / ulcers	Y
Angina pectoris / chest pains	Y	Sinus trouble	Y
Pace maker / defibrillator	Y	Breathing difficulties	Y
High / low blood pressure	Y	Asthma/ emphysema	Y
Rheumatic fever	Y	Tuberculosis	Y
Congenital heart defect / murmur	Y	Arthritis	Y
Artificial heart valve (Year replaced _____)	Y	Artificial joint (hip, knee, etc)	Y
Mitral valve prolapse / heart murmur	Y	Diabetes (Type_____)	Y
Stroke / aneurysm	Y	Thyroid disease	Y
Blood transfusion (Year_____)	Y	Kidney problems / failure / dialysis	Y
Anemia / Sickle Cell disease	Y	Drug / alcohol addiction	Y
Abnormal bleeding or healing	Y	Cancer / tumor (Type_____	
Fainting / dizzy spells	Y	Year_____)	Y
Severe headaches	Y	Radiation / x-ray treatment	Y
Epilepsy / seizures / convulsions	Y	Chemotherapy	Y
HIV positive / AIDS	Y	Autoimmune disorder (MS, Lupus, etc.)	Y
Possible exposure to communicable diseases	Y	Frequent nose bleeds	Y
Venereal Disease / STD	Y	Do you use tobacco/E products? (Type_____)	Y
Transplant (Type_____Year_____)		WOMEN: Are you pregnant or nursing	Y
Glaucoma	Y		
Hepatitis (Type_____)	Y		
Liver disease / cirrhosis / jaundice	Y	Birth control pills	Y

Have you had any operations, surgery or been hospitalized? _____
Do you have any conditions not listed above? _____

The information on this patient medical form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and or processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. Should there be any change in my medical condition prior to my next treatment, I promise to apprise my dentist in writing of the changes in my medical condition.

PATIENT'S SIGNATURE_____**DATE** _____

Medical updates: Date_____ Date_____ Date_____ Date_____ Date_____