RIVERDALE DENTAL ARTS

**, D.D.S. and Team**
545 West 236th Street, Riverdale, NY 10463 | Tel: 718-548-1148 | Fax: 718-548-0400
www.riverdaledentalarts.com

PLEASE COMPLETE AND RETURN TO THE BUSINESS OFFICE — FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party _____ Relationship _____ Date _____

## Patient Information

Last Name _____ First Name _____ Middle Name _____

Street Address / P.O. Box _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Birth Date (Mo/Day/Year) _____ Birthplace _____

Age: _____ Marital Status: Married Unmarried Separated

Social Security No. (if child, parent's) _____ Driver's License No. _____

Occupation _____ Employer _____ How Long Employed? _____

Employer Address & Phone No. _____

## Person Responsible for Bill (if different from patient)

Name _____ Age _____ Relationship _____

Address _____ Social Security No. _____ Driver's License No. _____

Occupation _____ Employer _____ How Long Employed? _____

Employer Address & Phone No. _____

## Insurance Information

Insured Person's Full Name _____ Date of Birth _____

Social Security Number _____ Relationship to Patient _____ Work Phone _____

Insurance Company Name _____ Group / Union Name _____ Group or Local Number _____

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Employer's Name | Full Address of Employer

## Getting to Know You

1. Why did you select our practice?

2. Whom may we thank for referring you?

3. Is another member of your family or a relative a patient in our practice?

4. Person to contact for emergency | Phone

5. When was your last dental visit?

6. When was the last time you had complete dental radiographs (x-rays) taken?

Name and Address of Last Dentist

7. Have you ever had any teeth removed? Yes No

How long have these teeth been missing? | Have these teeth been replaced?

How? Bridge Partial Denture Implants

## Payment Alternatives — Please Check Appropriate Box

1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.
2. Cash and personal checks are accepted as your treatments are provided.
3. If you have dental insurance, we want you to receive the full benefit of it. Our team can assist you in completing your insurance forms and verifying coverage. We accept assignment of your insurance payment, another service to you. Please note: you are responsible for your deductible and any portion insurance does not cover, and you remain responsible for the account if the insurance company, for any reason, does not honor its commitment.
4. Mastercard, Visa, Discover and American Express.
5. For long term or extended payments, we offer a healthcare financing program which, once you are extended a line of credit, allows small monthly payments for the treatment received.

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# MEDICAL HISTORY

Patient Name

1. How do you feel about getting and maintaining a healthy mouth?

2. How do you feel about the appearance of your teeth?

3. If you could change anything about your smile, what would you change?

4. Are you having dental problems at this time? **Yes** **No**

5. Do your gums bleed at any time? **Yes** **No**

6. Do you feel very nervous about having dental treatment? **Yes** **No**

7. Have you ever had a bad experience in the dental office? **Yes** **No**

8. Have you been under the care of a medical doctor during the past two years? **Yes** **No**

9. Have you been a patient in the hospital during the past two years? **Yes** **No**

10. Have you taken any medicine or drugs during the past two years? If yes, please list below: **Yes** **No**

11. Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list below: **Yes** **No**

12. Have you ever had excessive bleeding requiring special treatment? **Yes** **No**

13. Do you use any smoking, vaping, or tobacco products? If yes, please list below: **Yes** **No**

14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? **Yes** **No**

15. Do your ankles swell during the day? **Yes** **No**

16. Have you lost or gained more than 10 pounds in the last year? **Yes** **No**

17. Do you use more than 2 pillows to sleep? **Yes** **No**

18. Do you ever wake up from sleep short of breath? **Yes** **No**

19. Are you on a special diet? **Yes** **No**

If yes to #8 or #10-#13, please explain / list, and for #8 provide your physician's name, address, and phone number:

**20. Check any of the following which apply, past or present:**

| | | |
|---|---|---|
| Asthma | Emphysema | Shortness of Breath |
| Allergies or Hives | Fainting or Dizzy Spells | Epilepsy or Seizures |
| Nervousness | Psychiatric Treatment | Any Form of Eating Disorder |
| Recreational Drug Use | Drug Addiction / Alcoholism | Tuberculosis (TB) |
| Any Form of Hepatitis | Liver Disease | Auto Immune Disease |

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| | | |
|---|---|---|
| Acid Reflux | Arthritis | Heart Failure |
| Heart Disease or Attack | Family History of Cardiovascular Disease | Angina Pectoris (chest pain) |
| Rheumatic Fever | Congenital Heart Lesions | Scarlet Fever |
| Artificial Heart Valve | Heart Pacemaker | Heart Surgery |
| Artificial Joint of Any Type | Diet Medication (Name: _____) | Blood Transfusion |
| Hemophilia | Sickle Cell Disease | High Blood Pressure |
| Anemia | Pain in Jaw Joints | Cancer or Tumors |
| Radiation Treatment | Chemotherapy (Cancer, Leukemia) | Thyroid Disease |
| Glaucoma | HIV Positive (AIDS) | Venereal Disease |
| Cold Sores or Fever Blisters | Kidney Trouble | Diabetes |
| Ulcers | Stroke | Birth Control Medication |
| Pregnant – Due Date: _____ | | |

21. Do you have any disease, condition, or problem not listed? If so, please list: **Yes** **No**

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## SMILE EVALUATION

Patient Name

1. Do you like the way your teeth look? **Yes** **No**
2. Are you happy with the color of your teeth? **Yes** **No**
3. Would you like your teeth to be whiter? **Yes** **No**
4. Would you like your teeth to be straighter? **Yes** **No**
5. Do you have spaces between your teeth you would like closed? If so, where? **Yes** **No**
6. Would you like your teeth longer? **Upper** **Lower**
7. Do you have missing teeth you would like replaced? **Yes** **No**
8. Do you like the shape of your teeth? **Yes** **No**
9. Do you have old silver fillings you would like replaced with tooth-colored fillings? **Yes** **No**

Explain:

10. If you could change anything about your smile, what would you change?

I agree to let the Riverdale Dental Arts team take photos of me to utilize for educational or promotional purposes.

Signature Date

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# VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT CARE

Patient Name _____ Date of Birth _____

In accordance with the provisions of Section 164.510(b) of the Health Insurance Portability and Accountability Act (HIPAA), I agree that Riverdale Dental Arts and its duly authorized agents and employees may disclose Protected Health Information directly relevant to involvement with my care, or payment related to my care, to my family members, other relatives, close personal friends, or any other individuals that I indicate below who may contact Riverdale Dental Arts on my behalf.

Name of Individual(s) and Relationship (please print). Check the box next to the name to identify the type of information to be disclosed:

Dental Billing Name / Relationship: _____

Dental Billing Name / Relationship: _____

I do NOT want Riverdale Dental Arts to disclose information to anyone besides myself.

I understand:

• At any time, I may add or remove individuals from this list by notifying the office of my desire to do so. Until such notification, the office may rely on this list and disclose information to the individuals listed above.

• FOR DENTAL — The permission granted in this form is for the current visit only and will expire at the time of discharge.

• FOR BILLING — The permission granted is valid until I have notified the facility to change the list and is valid for the current visit only. Permission expires at the time the current bill is paid in full.

Visitor _____

Visitor _____

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or non-communicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances, including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers, or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified. I understand that my medical information may indicate that I have or have not been treated for psychological or psychiatric conditions or substance abuse.

Signature of Patient or Patient Representative _____ Date _____

Patient Parent of Minor Guardian Power of Attorney

Description of Representative's Authority to Act for the Patient _____

## Revocation of Verbal Disclosure

I may revoke this permission at any time, in writing, except revocation will not apply to information already disclosed in response to this permission.

Patient / Patient Representative Signature _____ Date _____ Revocation Signed _____

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# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**You May Refuse to Sign This Acknowledgement**

I, _____, have received a copy of Riverdale Dental Arts's Notice of Privacy Practices.

Please Print Name:

_____

_____ _____
Signature Date

## For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify): _____

*To be retained in the patient's file.*

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# CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of Riverdale Dental Arts and/or dental auxiliaries of his/her choice to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anaesthesia, radiographs (x-rays), or diagnostic aids:

   A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.

   B. Application of plastic “sealants” to the grooves of the teeth.

   C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).

   D. Replacement of missing teeth with dental prostheses (fixed bridges, removable partial or full dentures, implants).

   E. Removal (extraction) of one or more teeth.

   F. Treatment of diseased or injured oral tissues (hard and/or soft).

   G. Use of sedative drugs to control apprehension and/or disruptive behavior.

   H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

   I. Use of general anaesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in this treatment and acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anaesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well-being in the professional judgment of the dentist.

5. There are possible risks and complications associated with the administration of local anaesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration, and infection of the mucosa. I also understand that rare potential risks exist, such as unfavorable reactions to medications resulting in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials, and treatment records for the purposes of teaching, research, and scientific publications.

7. I understand that the success of the dental treatment provided requires that the patient (and parents, if applicable) follow post-operative and post-care instructions of the dentist(s), and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

| Date | Time (AM/PM) | File No. |
|---|---|---|

Patient's Name

Name of Parent or Guardian

Relationship to Patient