RYAN LONG DDS LLC

welcome!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

Email Address: _____

Name: _____

I prefer to be called: _____ ❍ Male ❍ Female

Birthday: ____/____/____ Age:____ SS#: _____

Home Address: _____

Apt./Condo #

_____

City State Zip

❍ Single ❍ Married ❍ Partnered ❍ Divorced/Separated ❍ Widowed

Hm # ( ) _____ Cell #: _____

Wk #: ( ) _____ Ext:_____ DL #:_____

Employer: _____

Employer's Address: _____

_____

City State Zip

Low long there?_____ Occupation: _____

Where & when are best times to reach you?_____

Whom may we thank for referring you? _____

Other family members seen by us:_____

Previous / Present Dentists: _____

Circle One

Person Responsible for Account: _____

2 Spouse Information

His / Her Name:_____

Employer:_____

Wk #: ( ) _____ Ext:_____ DL #:_____

Birthday: ____/____/____ SS#:_____

Relative or friend not living with you.

His/ Her Name:_____ Relation: _____

Wk #: ( ) _____ Hm #: ( ) _____

3 Insurance

Primary Insurance

Dental Coverage? ❍ Yes ❍ No

Insurance Co. Name: _____

Insurance Co. Address:_____

_____

City State Zip

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local or Policy #): _____

Insured's Name:_____ Relationship: _____

Insured's Birthday: ____/____/____ Insured's SS #: _____

Insured's Employer:_____

Employer's Address: _____

_____

City State Zip

Secondary Insurance

Dental Coverage? ❍ Yes ❍ No

Insurance Co. Name: _____

Insurance Co. Address:_____

_____

City State Zip

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local or Policy #): _____

Insured's Name:_____ Relationship: _____

Insured's Birthday: ____/____/____ Insured's SS #: _____

Insured's Employer:_____

Employer's Address: _____

_____

City State Zip

Payment is due in full at the time of treatment

unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date