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

DENTAL HISTORY

Name of former dentist _____

Date of last dental examination _____

Why are you seeking dental care today? _____

How did you hear about us?

❍ Yellow Pages ❍ Internet ❍ Friend ❍ Family Member ❍ Other

❍ Referral, whom _____

	YES	NO
Do you have teeth sensitive to cold?	❍	❍
Do you have teeth sensitive to hot?	❍	❍
Do you have teeth sensitive to sweets?	❍	❍
Do you have teeth sensitive to pressure?	❍	❍
Do you catch food between any teeth?	❍	❍
Do your gums bleed when you brush?	❍	❍
Have you had periodontal treatment?	❍	❍
Do you have swelling or lumps in your mouth?	❍	❍
Have you had frequent blisters or sores on your lips or mouth?	❍	❍
Do you have pain or noise in your jaw joint?	❍	❍
Do you grind or clench your teeth?	❍	❍
Have you ever been treated for a TMJ disorder?	❍	❍
Have you had orthodontic treatment?	❍	❍
Have you had root canal treatment?	❍	❍
Have your wisdom teeth been removed?	❍	❍
Do you have any missing teeth?	❍	❍
If yes, are you interested in replacing them?	❍	❍
Would you like to keep your teeth to avoid dentures?	❍	❍
Are you satisfied with your smile and the appearance of your teeth?	❍	❍
Have you been satisfied with your previous dental care?	❍	❍

If not, please explain _____

How often do you brush your teeth? _____

What texture is your toothbrush? Soft ❍ Medium ❍ Hard ❍

How often do you floss your teeth? _____

Is there any information not listed above that you feel is important to your dental care? _____

Please explain _____

_____

_____

_____

MEDICAL HISTORY

Please check correct response and indicate any medications taken where appropriate.

Patient's Name _____

Name of Medical Doctor _____

Date of last physical examination _____

	Yes	No
Are you presently under the care of a physician? _____	❍	❍
If so, for what? _____		
Has there been any change in your health within the past year? _____	❍	❍
What medications are you taking? _____		
_____		
_____		
Allergy to penicillin, or other antibiotics _____	❍	❍
List any other allergies_____		
Allergy to latex _____	❍	❍
Rheumatic Fever _____	❍	❍
Heart Murmur _____	❍	❍
Mitral Valve Prolapse _____	❍	❍
Heart ailments, disease _____	❍	❍
Heart surgery _____	❍	❍
Pacemaker _____	❍	❍
Artificial (prosthetic) heart valve _____	❍	❍
Previous infective endocarditis _____	❍	❍
Damaged valves in transplanted heart_____	❍	❍
Congenital heart disease (CHD) _____	❍	❍
Unrepaired, cyanotic CHD _____	❍	❍
Repaired (completely) in last 6 months _____	❍	❍
Repaired CHD with residual defects _____	❍	❍
High blood pressure _____	❍	❍
Anticoagulant therapy _____	❍	❍
Excessive bleeding from a cut, surgery or extraction _____	❍	❍
Anemia, blood problems, leukemia _____	❍	❍
Have you ever required a blood transfusion? _____	❍	❍
Prosthetic joint surgery _____	❍	❍
Date:_____ If yes, have you had any complications?	❍	❍
Emphysema, asthma _____	❍	❍
Do you smoke or use tobacco of any kind? _____	❍	❍

Doctor's Signature _____

Blood Pressure_____/_____

	Yes	No
Ulcer, colitis _____	❍	❍
Hepatitis, liver disease _____	❍	❍
Kidney trouble, dialysis _____	❍	❍
Thyroid disorder_____	❍	❍
Diabetes _____	❍	❍
How is it controlled? _____		
Long-term steroid therapy _____	❍	❍
Hormone Therapy (incl. birth control pill) _____	❍	❍
Arthritis, rheumatism _____	❍	❍
Eye disorders, glaucoma _____	❍	❍
Fainting spells, epilepsy, convulsions _____	❍	❍
Neurological problems _____	❍	❍
Psychiatric Care_____	❍	❍
Frequent headaches _____	❍	❍
Alcoholism, drug abuse _____	❍	❍
Malignancies_____	❍	❍
Radiation treatments/chemotherapy _____	❍	❍
Venereal disease, Herpes _____	❍	❍
Do you have any reason to believe that you may have been exposed to HIV, the virus that causes AIDS? _____	❍	❍
Are you pregnant? _____	❍	❍
If so, what month? _____		
Do you have any disease, condition, allergy or problem not listed? _____	❍	❍
If so, explain _____		
Have you ever had:		
1. Exposure to a person with tuberculosis _____	❍	❍
2. Tuberculosis _____	❍	❍
3. A positive skin test for tuberculosis _____	❍	❍
4. Have you had a chest x-ray follow up _____	❍	❍
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❍	❍

Name of physician or dentist

_____

Phone: _____

The undersigned agrees that the information above is accurate.

Signature _____ Date_____

HEALTH STATUS CHANGES

Date	Change in Health Status	Blood Pressure	Patient's Signature	Reviewed By
		/		
		/		
		/		
		/		
		/		
		/		
		/		
		/		