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

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
		/		
		/		
		/		
		/		
		/		
		/		
		/		
		/		

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 ______

______

______

______

Financial Agreement

Thank you for choosing ***Ryan Long DDS, LLC*** for your dental needs. We are committed to providing you with the highest quality of dental care possible. Because we value relationships first and foremost, you can always count on us to do everything possible to minimize confusion or frustration around fees and payments. We do this by inviting clear communication about both clinical care and the financial aspects of our work together. With that in mind, we've put together this document to help you understand what our expectations are around your financial responsibility.

- We ask that you provide us with the most correct and updated information about your insurance. *You will be responsible for any charges incurred if the information provided is not correct.*
- You may not know that your dental benefits are based upon a contract made between you and your employers chosen insurance company. If you have any questions regarding your dental benefits, **please contact your employer or dental insurance directly.** Dental benefit plans will never pay for all of your dental care. It is only meant to assist you.
- We estimate your portion based on the most up to date information we have, and it is only an **estimate**. If you prefer to have a potentially more accurate estimate directly from your insurance carrier, we are happy to file a "pre-treatment authorization". This process will delay treatment, and is still not considered a guarantee of payment.
- **We bill your insurance as a courtesy.** If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. Although this is rare, it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. We do everything we can to help you receive your benefits, and yet ultimately, you are responsible for all charges incurred at our office.
- We require payment in full for your portion at the time of service. We accept American Express, MasterCard, Visa, Discover, cash and checks. If you prefer an extended finance option, we also work with CareCredit.

A specific amount of time is reserved for you and **we strongly encourage all patients to keep their appointments.** If you must change your appointment, we require at least 2 business days' notice to avoid broken appointment fees. After 2 rescheduled appointments, a non-refundable deposit may be required to reserve your future appointments. If you are more than 10 minutes late to a scheduled appointment, you may be asked to reschedule your appointment and you may be charged a late appointment fee.

By my signature below, I hereby authorize the Doctor and staff associated with Ryan Long DDS, LLC to release medical, dental and other information acquired in the course of my examination and or treatment to the necessary insurance companies and third party contracts.

I understand that I'm financially responsible for all charges incurred at this office.

____________________________ ________________________________

Printed Name Signature (parent if minor) Date

Ryan Long DDS,LLC
383 Regency Ridge
Dayton, OH 45459

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ______________________________, have received a copy of this office'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

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)____

Medical Information Release Form

(HIPAA Release Form)

Name: ______________________________ Date of Birth: ____/____/______

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ____

[ ] Child(ren) ____

[ ] Other ____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: __________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other _______________________________________

Signed: ___________________________________ Date: ____/____/______