

DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

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www.drroylong.com

Date _____ Home Phone (_____) _____ Cell Phone (_____) _____

PATIENT INFORMATION

Name _____
Last Name First Name Middle Initial SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (_____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (_____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (_____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand
that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and
their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This
consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

Date _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Relationship to Patient _____

DENTAL HEALTH HISTORY (Confidential)

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) Yes No

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate date(s) _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Latex _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Anesthetic | _____ |
| <input type="checkbox"/> Penicillin | _____ |

SIGNATURE

The above information is accurate and complete to the best of my knowledge. 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.

Date _____ Signature _____

Troy L. Long, D.D.S.
229 West Gay Street
Lebanon, TN 37087
Office 615.444.2782
Fax 615.444.4354

Office Financial Policy

Payment for services are expected and due at the time the services are provided. For your convenience, we accept CHECKS, CASH, VISA, MASTER CARD, DISCOVER, AMERICAN EXPRESS, DEBIT/BANK CARDS. We will offer a 5% Cash discount for treatment paid in advance in full by the method of cash or check.

Regarding Insurance

We will attempt to verify your insurance coverage and calculate your deductible and co-payments as accurately as possible. All services rendered are charged directly to the patient, and the patient (and/or responsible party) is ultimately responsible for the account regardless of insurance coverage. Please understand that your insurance policy is a contract between you and your insurance company. It is not up to us to determine what services they will and will not cover.

As a courtesy to you, we will file your insurance for you, and we may accept direct payment from most insurance companies. **If you have a deductible and/or a co-payment you will be required to pay it at the time the services are provided. Failure to collect a patient's deductible and/or co-pay is considered insurance fraud.** Once payment is received on your claim, we will send you a bill for any balance remaining on your account. Payment will be due upon receipt. Please note that if your insurance has not paid within 60 days, you will be responsible for your account balance.

Past-Due Account Balances

Interest of 1.5% per month (18% annual rate) will be charged to accounts over 60 days. Accounts over 90 days past due may be reported to the Credit Bureau of North America and Experian. A late fee up to \$50.00 may be applied to accounts over 90 days. Patients will be responsible for all collection cost, court cost and/or attorney fees which could incur as a result of collecting on an account that has been turned over to a collection agency.

Payment Plans

We do offer payment plans for those with approved credit* through a third party financing company (Care Credit/ Chase Health Advantage). Please see a member of our front office team for more information.

I have read and understand the above financial policy. By signing below, I acknowledge responsibility and agree to the terms as stated above.

Signature of Patient/or Responsible Party

Date

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PATIENT CONSENT & ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Troy L. Long, D.D.S., our staff, and our business associates for treatment, payment, and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices. You have the right to review our Notice of Information consent. The terms of this notice may change. If the terms do change, you may obtain a revised notice by simply contacting our office at 615.444.2782 and requesting a revised notice. We will also post any revised notice in our office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the rights to refuse to treat you, should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

NAME

DATE

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE
CONSENT/ACKNOWLEDGEMENT OF NOTICE OF PRIVACY.
