Patient Registration

First Name:_____ Last Name:_____ MI:_____
Patient Is: O Policy Holder Preferred Name:_____
O Responsible Party

How did you hear about our office? _____

Address:_____

City, State, Zip:_____ Cellular:_____

Home Phone:_____ Work Phone:_____ Ext:_____

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Birthdate: _____ Age:_____ Soc. Sec:_____ Drivers Lic:_____

Email:_____ ___ O I would like to receive correspondences via email.
Would you also like to receive correspondences via text message to your cellular phone?_____

Responsible Party (if someone other than the patient)_____

Address:_____

City,State,Zip:_____ Cellular:_____

Home Phone:_____ Work Phone:_____ Ext:_____

Birthdate:_____ Soc. Sec:_____ Drivers Lic:_____
O Responsible Party is also a Policy Holder for Patient O Primary Insurance Holder O Secondary Insurance Holder

Patient Employment Status: O Full Time O Part Time O Retired
Student Status: O Full Time O Part Time

Emergency Contact: _____ **Emerg. Contact Phone#:** _____
Physician: _____ **Spouse:** _____
Pref. Pharmacy: _____ **Patient Employer:** _____
Pharmacy Phone #: _____
Special Considerations (i.e. gag reflex, anxiety, light sensitivity): _____

_____

Primary Insurance Information
Name of Insured:_____ Insured Soc. Sec:_____
Insured Date of Birth:_____ Relationship to insured:_____
Employer:_____ Insurance Company:_____

Secondary Insurance Information
Name of Insured:_____ Insured Soc. Sec:_____
Insured Date of Birth:_____ Relationship to insured:_____
Employer:_____ Insurance Company:_____

Eaglesoft Medical History - Custom (A)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Are you taking a bloodthinner?	Yes No	If yes
Are you required to take an antibiotic prior to having dental, surgical, or other invasive medical procedures?	Yes No	If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?		If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
Yellow Jaundice Yes No			

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Troy Long, DDS

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Troy Long, DDS. I hereby authorize, as indicated by my signature below, Troy Long, DDS to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____ Date __/__/____ Relationship: _____

2. _____ Date __/__/____ Relationship: _____

3. _____ Date __/__/____ Relationship: _____

4. _____ Date __/__/____ Relationship: _____

* * *

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 the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

PATIENT CONSENT

Clinical

1. I authorize Troy Long, DDS to perform all recommended treatment.

2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Insurance

4. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

5. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____

Patient's Address: _____

Signature: _____Relationship: _____ Date: _____

If patient is a child, please provide the parental or legal guardian's consent:

Troy Long, DDS

OUR OFFICE, YOUR INSURANCE PLAN AND HOW THEY WORK TOGETHER

Our office is pleased that you have insurance benefits to help you with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process, so we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE, AND HOW MUCH WILL THEY PAY?

We currently accept most private care insurance (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with literally thousands of companies. We are also in network providers for a select number of companies including BCBS, Cigna, Delta, Dentemax, Guardian & Assurant. Although we can maintain computerized histories of payment by a given company, they do change; THEREFORE IT IS IMPOSSIBLE TO GIVE YOU A GUARANTEED QUOTE AT THE TIME OF SERVICE. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL, WHY?

We based patient portion of your bill on our most current data but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to visiting our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so that we may adjust accordingly.

INSURANCE DID NOT PAY, NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to require payment in full for services from you and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS

Our office does require payment in full for your estimated portion at the time of service. If you are in need of an extended option, please just ask one of the patient services staff for an application. We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Dr. Troy Long's Office.

Signature_____ **Date**_____

Troy L. Long, D.D.S.
212 North Castle Heights Avenue
Suite A
Lebanon, TN 37087
615.444.2782

PATIENT CONSENT & ACKNOWLEDGMENT FORM

By signing below, you consent to the use of your e-signature by Troy L. Long, D.D.S., our staff, and our business associates for treatment, payment, and health care operations. 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 with your request. We will also post any revised notice in our office.

You have the right to request that we restrict our uses of your e-signature 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 of your e-signature, but this must be in writing.

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF USE OF E-SIGNATURE 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 USE OF E-SIGNATURE.

_____ _____

NAME DATE

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE CONSENT/ACKNOWLEDGEMENT OF NOTICE OF USE OF E-SIGNATURE.

NOTICE REGARDING USE OF E-SIGNATURE FOR TROY L. LONG, D.D.S.

Pursuant to Tennessee Code §47-10-102, the following definitions regarding e-signatures constitute an agreement between you and Troy L. Long, D.D.S.

DEFINITIONS

1. ***Automated transaction*** means a transaction conducted or performed, in whole or in part, by electronic means or electronic records, in which the acts or records of one or both parties are not reviewed by an individual in the ordinary course of forming a contract, performing under an existing contract, or fulfilling an obligation required by the transaction.

2. ***Electronic*** means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

3. ***Electronic signature*** means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

4. ***Information*** means data, text, images, sounds, codes, computer programs, software, databases, or the like.

5. ***Person*** means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, governmental agency, public corporation or any other legal or commercial entity.

6. ***Record*** means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

7. ***Security procedure*** means a procedure employed for the purpose of verifying that an electronic signature, record, or performance is that of a specific person or for detecting changes or errors in the information in an electronic record. The term includes a procedure that requires the use of algorithms or other codes, identifying words or numbers, encryption, callback or other acknowledgment procedures.

8. ***Transaction*** means an action or set of actions occurring between two (2) or more persons relating to the conduct of business, commercial, or governmental affairs.

NOTICE REGARDING ELECTRONIC COMMUNICATIONS

You agree your electronic signature is the legal equivalent of your manual signature on this Agreement. By signing, you consent to be legally bound by this Agreement's terms and conditions. You further agree that your use of a key pad, mouse or other devise to select an item, button, icon or similar act/action, or to otherwise provide Troy L. Long, D.D.S. instructions, or in accessing or making any transaction regarding any agreement, acknowledgement, consent terms, disclosures or conditions constitutes your signature (hereafter referred to as "E-Signature"), acceptance and agreement as if actually signed by you in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature and that the lack of such certification or third

party verification will not in any way affect the enforceability of your E-Signature or any resulting contract between you and Troy L. Long, D.D.S. You also represent that you are authorized to enter into this Agreement for all persons who own or are authorized to access your account and that such persons will be bound by the terms of this Agreement. You further agree that each use of your E-Signature in obtaining service constitutes your agreement to be bound by the terms and conditions of the Agreement as it exists on the date of your E-Signature.

You specifically agree to receive and/or obtain any and all related "Electronic Communications" from Troy L. Long, D.D.S. The term "Electronic Communications" includes, but is not limited to, any and all current and future notices and/or disclosures that various federal and/or state laws or regulations require that we provide you, as well as such other documents, statements, data, records and any other communications regarding your relationship with Troy L. Long, D.D.S.. You acknowledge that, for your records, you are able to retain Electronic Communications by printing and/or downloading and saving this Agreement and any other agreements and Electronic Communications, documents, or records that you agree to using your E-Signature. You accept Electronic Communications provided by Troy L. Long, D.D.S. as reasonable and proper notice, for the purpose of any and all laws, rules, and regulations, and agree that such electronic form fully satisfies any requirement that such communications be provided to you in writing or in a form that you may keep.

You may request a paper version of an Electronic Communication. You acknowledge that Troy L. Long, D.D.S. reserves the right to charge you a reasonable fee for the production and mailing of paper versions of Electronic Communications. To request a paper copy of an Electronic Communication contact us at (615) 444-2782.

You have the right to withdraw your consent to receive/obtain communications at any time. You acknowledge that Troy L. Long, D.D.S. reserves the right to restrict or terminate your access if you withdraw your consent to receive Electronic Communications. If you wish to withdraw your consent, contact us at (615) 444-2782.

Your current valid email address is required in order for you to obtain online services. You agree to keep Troy L. Long, D.D.S. informed of any changes in your email address. You may modify your email address by submitting a written request to Troy L. Long, D.D.S. or submit a secure message through email. Troy L. Long, D.D.S. may notify you through email when an Electronic Communication or updated agreement is available.

This Agreement supplements and modifies other agreements that you may have with Troy L. Long, D.D.S. To the extent that this Agreement and another agreement contain conflicting provisions, the provisions in this agreement will control (with the exception of provisions in another agreement for an electronic service which provisions specify the necessary hardware, software and operating system, in which such other provisions controls). All other obligations of the parties remain subject to the terms and conditions of any other agreement.

_____ _____

NAME DATE