Southern Smiles
DENTAL PRACTICE

KEITH M. LONG, DDS
HENRY A. LONG JR, DDS

755 11th STREET • LAKEPORT, CA 95453 • (707) 263-7023

PATIENT INFORMATION

Name ______________________________ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: __________
First MI Last

Address ______________________________ Occupation: ____________________ [ ] Male [ ] Female

City ____________________ State ________ Zip __________ Hm# (____)____________________

Employer ______________________________ Wk# (____)______________Ext ________

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell # (____) ____________________

DOB: ____/_____/______ SSN# ____________________ E-mail ______________@____________

Spouse's Name ______________________________
First MI Last (if different)

Spouse occupation ____________________ Work phone ____________________Ext __________

Is patient a full time student? [ ] No [ ] Yes: Name of school: ______________________________

RESPONSIBLE PARTY (if different than patient)

Name ______________________________ Relationship to patient:____________________
First MI Last

Address ______________________________

City ______________________________ State __________ Zip __________

Hm# (_____)____________________ Wk# (_____)____________________

DOB: ____/_____/______ SSN#______________________________

YOUR PREFERENCES

Do you prefer appointment reminders by: [ ] Email [ ] Phone [ ] Text

Do you prefer to receive calls from our office at: [ ] Home [ ] Work [ ] Cell

Whom may we thank for referring you? ______________________________

How do you wish to be addressed by our staff?______________________________

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name ______________________________ Relationship to patient: ____________________

DOB: ______/______/_________ Subscriber's SSN# ______________________________

Insurance Company ____________________ Policy # ______________ Group #________________

DENTAL INSURANCE:

Insured Name ______________________________ Relationship to patient: ____________________

Address ______________________________ City ____________________ State ______ Zip ________

DOB: ____/____/_______ SSN# ____________________ Employer: ______________________________

Insurance Company ____________________ Group # ____________________ Eff. Date: ___/___/____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name ______________________________ Relationship to patient: ____________________

Address ______________________________ City ____________________ State ______ Zip ________

DOB: ____/____/_______ SSN# ____________________ Employer: ______________________________

Insurance Company ____________________ Group # ____________________ Eff. Date: ___/___/____

MEDICAL HISTORY and CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Allergies

Acrylics Y N
Latex Y N
Local Anesthetics Y N
Penicillin Y N
Metal Y N
Sulfa Y N
Other Y N

____

____

Cardiovascular

Artificial Heart Valve Y N
Coronary Artery Disease Y N
Chest Pain or Angina Y N
Congestive Heart Failure Y N
Heart Attack Y N
High Blood Pressure Y N
High Cholesterol Y N
Low Blood Pressure Y N
Pacemaker Y N
Tachycardia Y N

Endocrine

Diabetes Y N
Hormonal Change Y N
Thyroid problems Y N

Eyes, Ears, Nose and Throat

Glaucoma Y N
Nose Bleeding Y N
Sinus Problems Y N

Women Only

Are you pregnant? Y N
Are you nursing? Y N

Gastrointestinal

Acid Reflux Y N
GERD Y N
Ulcers Y N

Genitourinary

Frequent Urination Y N
Kidney disease Y N

General

Current weight:__________lbs.
Height:________ft________in
Cancer Y N
Bisphosponates Y N
Headaches Y N
HIV/AIDS Y N
Knee/hip replacement Y N
Liver problems Y N
Recent Trauma or Injury Y N
Rheumatic Fever Y N
Radiation Treatment Y N

Hematological

Bleeding problems Y N
Hepatitis Y N

Oral

Bleeding gums Y N
Dry mouth Y N
Jaw problems (TMJ)? Y N
Clicking? Y N
Pain? Y N
Difficulty swallowing? Y N
Difficulty chewing? Y N
Orthodontics/Invisalign Y N
Teeth clenching/grinding Y N
Tooth pain Y N
Do you wear removable teeth? Y N

Do you take or need antibiotics before dental procedures? Y N

Musculoskeletal

Back Pain/Joint Y N
Fibromyalgia Y N

Neurological

Alzheimer's Disease Y N
Dizziness Y N
Fainting Y N
Multiple Sclerosis (MS) Y N
Seizures Y N
Stroke Y N
Trigeminal Neuralgia Y N
Tremor Y N

Psychiatric

ADD/ADHD Y N
Anxiety Y N
Chemical Dependency Y N
Depression Y N
Eating disorders Y N
Excessive Stress Y N

Respiratory

Asthma Y N
Bronchitis Y N
Congestion Y N
Dyspnea(shortness of breath) Y N
Emphysema Y N
Pneumonia Y N
Pulmonary Embolism Y N
Tuberculosis Y N

Sleep

Daytime Sleepiness Y N
Morning headaches Y N
Obstructive Sleep Apnea Y N
Do you use a CPAP? Y N
How often? _______________

Has anyone told you that you snore? Y N

Social History

Do you smoke? Y N ___ packs a day
Do you use smokeless tobacco? Y N
Do you consume alcoholic beverages? Y N
_____Drinks per day/week/month
Do you use recreational drugs? Y N

CONFIDENTIAL

MEDICAL HISTORY and CONSENT

List any medications you are taking:

	Medication	Dosage/Freq.	Prescriber	Reason
1.				
2.				
3.				
4.				

List any surgeries or hospitalizations you have had:

Date(year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above:

____

____

Primary Physician's Name: ____________________ Physician's phone #: ____________________

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Keith M. Long, D.D.S. and Henry A. Long Jr., D.D.S. to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Keith M. Long, D.D.S. and Henry A. Long Jr., D.D.S. to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Keith M. Long, D.D.S. and Henry A. Long Jr., D.D.S. choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Keith M. Long, D.D.S. and Henry A. Long Jr., D.D.S. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Keith M. Long, D.D.S. and Henry A. Long Jr., D.D.S. and staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits, and to handle any necessary claim appeal(s).

Consent (adult):
Name of Patient ____________________ ____________________ Date __________
Signature of Patient

Consent (for a minor child):
Name of Parent/Guardian ____________________ ____________________ Date __________
Signature of Parent/Guardian

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. By signing below you are acknowledging receiving notice of our practices' policies and your rights regarding PHI. I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

____________________ Date __________
Signature of Patient

CONFIDENTIAL