

# MICHAEL G. LONG D.D.S.

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ M/F  
Nick Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. \_\_\_\_\_  
School Attending \_\_\_\_\_ PT/FT Age \_\_\_\_\_ Single ☐ Married ☐ Divorced ☐ Widowed ☐

## ACCOUNT INFORMATION

Primary:  
Responsible Person

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ M/F  
Street \_\_\_\_\_ Employer Name \_\_\_\_\_  
City \_\_\_\_\_ Street \_\_\_\_\_  
State, Zip \_\_\_\_\_ City \_\_\_\_\_  
Home Phone No. \_\_\_\_\_ Cell# \_\_\_\_\_ State, Zip \_\_\_\_\_  
Single ☐ Married ☐ Divorced ☐ Widowed ☐ Work Phone No. \_\_\_\_\_ Ext. \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. \_\_\_\_\_

## INSURANCE COVERAGE

Insurance Carrier \_\_\_\_\_ Group No. \_\_\_\_\_ Effective Date \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Responsible Person Secondary:

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ M/F  
Street \_\_\_\_\_ Employer Name \_\_\_\_\_  
City \_\_\_\_\_ Street \_\_\_\_\_  
State, Zip \_\_\_\_\_ City \_\_\_\_\_  
Home Phone No. \_\_\_\_\_ Cell: \_\_\_\_\_ State, Zip \_\_\_\_\_  
Single ☐ Married ☐ Divorced ☐ Widowed ☐ Work Phone No. \_\_\_\_\_ Ext. \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. \_\_\_\_\_

## INSURANCE COVERAGE

Insurance Carrier \_\_\_\_\_ Group No. \_\_\_\_\_ Effective Date \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## GETTING TO KNOW YOU

- Has any member of your family been a patient here before? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, whom? \_\_\_\_\_ Relationship \_\_\_\_\_
- Whom may we thank for referring you to our office? \_\_\_\_\_
- Person to contact for emergency \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_
- Closest relative not living with you \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

## Consent For Treatment

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that 1-1/2% late charge (18%) may be added to my account. If required, I also understand a check of credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Responsible Party's Signature \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Name: \_\_\_\_\_ Medical Alerts: \_\_\_\_\_

Are you or have you taken: Boniva, Fosamax, Aredia, Actonel, Zometa. ....YES NO

1. Are you having pain or discomfort at this time? ..... YES NO  
2. Have you been a patient in the hospital during the past two years? ..... YES NO  
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

Physician's Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_

4. Have you taken any medication or drugs during the past two years? ..... YES NO  
5. Are you now taking any medication, drugs or pills? ..... YES NO

If yes, please list: \_\_\_\_\_

6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO  
If yes, please list: \_\_\_\_\_

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure ..... YES NO	Artificial Joints (hip, knee, etc.) ... YES NO	Hepatitis B (serum) ..... YES NO
Heart Disease or Attack ..... YES NO	Kidney Trouble ..... YES NO	Venereal Disease ..... YES NO
Angina Pectoris ..... YES NO	Ulcers ..... YES NO	A.I.D.S. .... YES NO
Congenital Heart Disease ..... YES NO	Diabetes ..... YES NO	H.I.V. Positive ..... YES NO
Heart Murmur ..... YES NO	Thyroid Problems ..... YES NO	Cold Sores/Fever Blisters ..... YES NO
High Blood Pressure ..... YES NO	Glaucoma ..... YES NO	Blood Transfusion ..... YES NO
Arteriosclerosis ..... YES NO	Cosmetic Surgery ..... YES NO	Hemophilia ..... YES NO
Mitral Valve Prolapse ..... YES NO	Emphysema ..... YES NO	Anemia ..... YES NO
Artificial Heart Valve ..... YES NO	Chronic Cough ..... YES NO	Sickle Cell Disease ..... YES NO
Heart Pacemaker ..... YES NO	Tuberculosis ..... YES NO	Bruise Easily ..... YES NO
Heart Surgery ..... YES NO	Asthma ..... YES NO	Liver Disease ..... YES NO
Rheumatic Fever ..... YES NO	Hay Fever ..... YES NO	Yellow Jaundice ..... YES NO
Arthritis ..... YES NO	Allergies or Hives ..... YES NO	Epilepsy or Seizures ..... YES NO
Rheumatism ..... YES NO	Sinus Trouble ..... YES NO	Fainting or Dizzy Spells ..... YES NO
Corisone Medicine ..... YES NO	Radiation Therapy ..... YES NO	Nervousness ..... YES NO
Drug Addiction ..... YES NO	Chemotherapy ..... YES NO	Psychiatric Treatment ..... YES NO
Stroke ..... YES NO	Hepatitis A (infectious) ..... YES NO	Developmentally Disabled ..... YES NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO  
9. Do your ankles swell during the day? ..... YES NO  
10. Do you use more than two pillows to sleep? ..... YES NO  
11. Have you lost or gained more than 10 pounds in the past year? ..... YES NO  
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO  
13. Are you on a special diet? ..... YES NO  
14. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO  
15. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO

If yes, please list: \_\_\_\_\_

**FOR WOMEN ONLY:**

Are you pregnant? ☐ Yes, what month? \_\_\_\_\_ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT:**

- The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
- I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) \_\_\_\_\_. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

# Michael G. Long D.D.S.

7730 N. Fresno St. # 102  
Fresno CA. 93720

## HIPAA Consent Form

The Health Insurance Portability and Accountability Act of 1996 provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. For this reason, our practice has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the rules of confidentiality.

4. The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties.

5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

6. Your confidential information will not be used for purposes of advertising or marketing of products, goods or services. Such prohibition does not include treatment/product samples or goods of nominal value.

7. The practice agrees to provide the patient with access to their records in accordance with state law.

8. The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

If 18yrs. or older I consent to have my dental treatment and billing discussed with my parents.

\_\_\_\_\_  
( Initial)

I, \_\_\_\_\_ do hereby agree to the terms set forth above and any subsequent  
( Patient or Guardian)  
changes in office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

\_\_\_\_\_  
( Signature)

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Patient Acknowledgement of Receipt of  
Dental Materials Fact Sheet

I, \_\_\_\_\_ acknowledge I have Received a copy of the Dental  
Patient's Name

Materials Fact Sheet from Dr Michael G. Long D.D.S.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_