Welcome to Long Falls Dentistry.

We’re glad you’re here.

We know that going to the dentist may not be at the top of your “to do” list. But whether it’s been six months or six years since your last visit, we're just glad you’re here.

We promise to listen to your hopes and fears, jitters and concerns. To provide care without pressure, and advice without obligation. To deliver equal doses of care and honesty, because we're confident you'll trust us with your mouth when you know we have your best interests at heart.

And we’ll stop at nothing to deliver an experience that is above and beyond what you thought dental care could be.

OFFICE USE ONLY: Acct #_____

Long Falls Dentistry

Patient Information

Please Print

Circle One: Dr/Mr/Mrs/Ms/Miss

First: _____ Middle: _____ Last: _____ Jr/Sr: ____

Street: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Work Phone: _____

Cell Phone:_____

Email Address:_____ May we contact you by email? (circle) **Yes No**

Patient Social Security Number:_____ Patient Date of Birth: _____Sex: (circle) **M F**

Emergency Contact: _____Phone: _____

How did you hear about Long Falls?

☐ Newspaper ☐ Radio ☐ TV ☐ Internet ☐ Referral ☐ Other:_____

Insurance Information

Do you have Dental Insurance? (circle) **Yes No** Do you have Secondary Dental Insurance? (circle) **Yes No**

Primary Insured		**Secondary Insured**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
insurance Phone #		insurance Phone #	
Please present your insurance card to our patient services representative to be photocopied			

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:

Name of Recipient:_____

Relationship to the Patient: _____

I give authorization to disclose the following information:

- ☐ All treatment information
- ☐ Information specifically related to these treatment dates

Starting Date:_____ End Date:_____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by noting Long Falls Dentistry in writing.

Signature of Patient (or Patient Representative)_____ Date:_____

Printed Name of Patient (or Patient Representative) _____

OFFICE USE ONLY: Acct #_____

Long Falls Dentistry

Health Information

Long Falls Dentistry takes your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may effect your treatment. All information is confidential.

Patient's Name: _____ Date of Birth:_____ Last Physical Date:_____

Physician's Name & Phone #:_____Reason for today's visit?_____

Work Related Injury? (circle) **Yes No** Have you been under the care of a physician? (circle) **Yes No**

Have you ever been hospitalized? (circle) **Yes No**

Height: _____ Weight:_____

Date of last dental visit:_____ Date of last dental x-rays:_____ Date of last cleaning:_____

Have you ever been treated for periodontal (gum) disease? (circle) **Yes No**

Ever had Novocaine or other local anesthetic? (circle) **Yes No**

Are you interested in tooth whitening? (circle) **Yes No**

If wearing dentures, age of dentures: _____ Are you interested in new dentures? (circle) **Yes No**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **Yes No**

Are you taking or have taken Oral Bisphosphonates?(e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, (e.g., ZOMETA, AREDIA) (circle) **Yes No** Taken for how long?_____

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes No**

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes No**

List any medications you are allergic to:

1._____ 2._____ 3._____ 4._____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Teeth Grinding/Clenching			Pace Maker/Heart Surgery			Asprin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pain in your jaw (TMJ)			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (Type:)		
Any type of Transplant			Heart Problem ( )			Excessive Bleeding			Any Artificial Hip. Knee or other Joint		
Drug Addiction			Dialysis			Stroke			Other Disease or Illness:		
Hepatitis (Type:)			Chemotherapy			Lung Disease					
Liver Disease			Radiation Treatment			Breathing Problems					
Kidney Disease			Use of Tobacco Products			Tuberculosis (TB)					

Women patients only:	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date: / /			Are you taking any birth control prescriptions?		

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

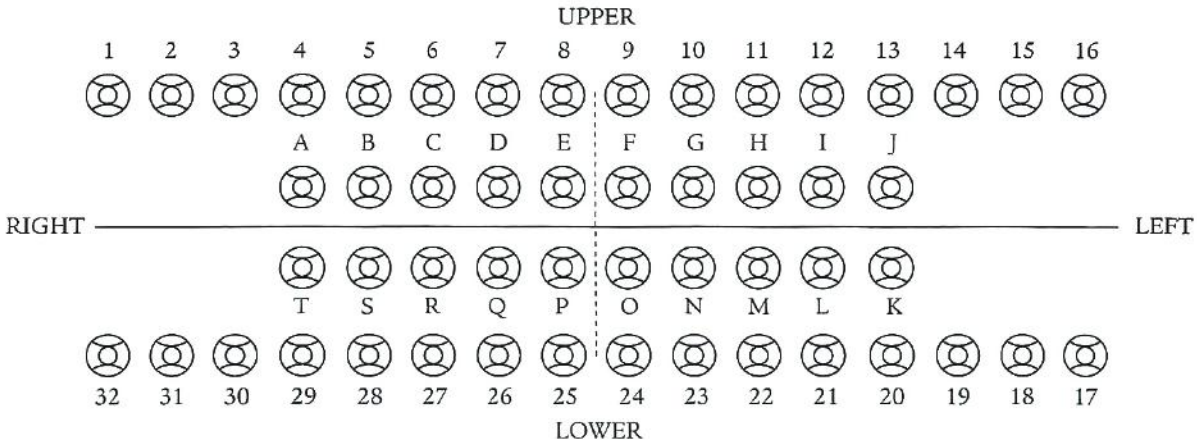
I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I here- by give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature .....Date ..... Dr's. Signature/Medical History Review ..... Date .....

6 MONTH Patient's Signature_____ Date_____ Dr's. Signature/Medical History Review_____ Date_____

Long Falls Dentistry

Treatment Planning



Patient Name:_____

Account Number: _____ Date of Exam:_____

Pre-Medication Required: Yes or No

PSR SCORE

Chief Complaint:_____

Med Hx: _____ Meds: _____

Allg: _____ EOE: _____

IOE: _____

_____

X-ray Findings: _____

_____

Oral Cancer Exam: _____ TMJ & Occlusion Class: _____

Initial Or Periodic Treatment Plan (Circle One)

_____

_____

_____

_____

X-rays Taken

PA	
BW	
PAN/FMS	

_____

_____

_____

_____

_____

_____

Provider's Signature/Date