



Dr. Gregory Long

(309) 692-2700

7131 N. Knoxville Suite B Peoria
212 N. Davenport Metamora

PATIENT REGISTRATION

date _____

PATIENT INFORMATION

Name _____ Gender _____

Address _____ City _____ State _____ ZIP _____

Home / Cell _____ Work _____ Age _____ Birthdate _____

Responsible Party _____ Relationship to Patient _____

Billing address _____ City _____ State _____ ZIP _____

Email _____

EMERGENCY CONTACT

Name _____

Relationship to Patient _____ Phone _____

IF PATIENT IS A MINOR

Parent _____ Parent _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Employer _____ Employer _____

IF PATIENT IS AN ADULT

Employer _____ Spouse _____

Position _____ Employer _____

OTHER QUESTIONS

Has any family member been a patient here before? _____ No _____ Yes

If so, who? _____

How did you hear about our office? _____

Has any family member worn braces before? _____ No _____ Yes

If so, who was the orthodontist? _____

HEALTH INFORMATION

The following questions are designed to obtain the patient's health history

Does the patient have or has the patient ever had any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma/Hay Fever |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Fainting Spells/Seizures | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stomach Ulcer |

Does the patient require antibiotics prior to treatment? _____ No _____ Yes ***(please list below)**

Is patient currently under care of physician for an illness/disease? _____ No _____ Yes ***(please list below)**

Has patient ever had trauma to face or teeth? _____ No _____ Yes ***(please list below)**

Does the patient have a bleeding tendency or do wounds heal slowly? _____ No _____ Yes

Has patient been on Fosamax or any Bisphosphonates (drugs that harden bone)? _____ No _____ Yes

Is patient **allergic to nickel, latex, any drugs/medications?** _____ No _____ Yes, please list _____

My chief concerns are: _____

Patient's dentist _____

City/State of patient's dentist _____

PLEASE CHECK ALL STATEMENTS BELOW THAT APPLY TO THE PATIENT

- Patient visits the dentist regularly, at least every _____ months.
- Patient's last cleaning was in the month of _____.
- Patient has not seen the dentist in _____ years.
- This is patient's first experience with an orthodontist.
- The patient has worn braces before.
- The patient has seen another orthodontist and would like a second opinion.

The Teeth

- There are spaces between the teeth the patient does not like.
- The teeth are crooked and overlapping
- The teeth stick out too far.
- The mouth seems too small, not enough room for the teeth.
- The teeth are coming in the wrong places.

The Bite

- The bite is comfortable, and the patient can eat with no difficulties.
- The patient feels there is a problem with the bite or has been told there is a problem.
- The patient has frequent or chronic pain in their jaws, face, or head.
- The patient's jaws click, pop or lock when they open their mouth.
- The patient has or has had difficulty in opening and/or closing their jaws.
- The patient clenches their teeth during the day or grinds their teeth during the night.
- There is a habit I am concerned about (thumb or finger sucking).

How Much Time are You willing to Commit to Orthodontic Treatment?

- The patient is willing to commit as much time and resources required, even if surgery is needed, to get the best cosmetic and functional results.
- The patient wants the best results that can be obtained without any facial/dental surgery.
- The patient wants to spend as little time as possible and is willing to accept compromises.

What Kind of Braces Does the Patient Want?

- The least expensive (silver metal).
- The most cosmetic (clear ceramic)
- Removable and cosmetic aligners.
- I need more information to make a decision.

How Soon Would You Like to Get Started?

- I would like to get started as soon as possible if it is determined that treatment is necessary.
- I want to discuss the findings with my spouse before making a decision to start treatment.
- I want to delay treatment as long as possible.

INSURANCE INFORMATION

Primary Insurance

Policy Holder _____ Birthdate ____/____/____

Employer _____

Insurance company _____

Policy/Group# _____

Member ID # or Social _____

Secondary Insurance

Policy Holder _____ Birthdate ____/____/____

Employer _____

Insurance company _____

Policy/Group# _____

Member ID # or Social _____

Insurance and Payment Authorization Release

I authorize the release of any information relating to this claim and understand that I am responsible for all costs of dental treatment.

Responsible Party Signature _____ Date ____/____/____

I hereby authorize payment directly to Gregory Long DMD MS PLLC of the group insurance benefits otherwise payable to me.

Responsible Party Signature _____ Date ____/____/____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

PARENT NAME _____

PATIENT NAME _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone: (309) 692-2700 Fax: (309) 692-5649

Address: 7131 N. Knoxville Ave. Suite B. Peoria, IL 61614

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____