WELCOME

Lyons Orthodontics

Pride in Every Smile

TODAY'S DATE: _______________

NAME_______________ I PREFER TO BE CALLED_______________

ADDRESS_______________ CITY_______________ STATE_________ ZIP_______________

AGE____________ BIRTHDATE___________________ ❑ MALE ❑ FEMALE SOCIAL SECURITY NUMBER: _______________

E-MAIL ADDRESS _______________ MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑PARTNERED ❑DIVORCED ❑SEPARATED ❑WIDOWED

HOME PHONE _______________ CELL PHONE _______________

WORK PHONE _______________ DRIVERS LICENSE# _______________

EMPLOYER_______________ HOW LONG? ________ OCCUPATION_______________

ADDRESS_______________ CITY_______________ STATE_______ ZIP____________ PHONE_______________

WHEN ARE THE BEST TIMES TO REACH YOU? _______________ OTHER FAMILY MEMBERS SEEN BY US _______________

RELATIVE OR FRIEND NOT LIVING WITH YOU:

NAME_______________ RELATION _______________

HOME PHONE_______________ WORK PHONE _______________

GENERAL DENTIST _______________ PHONE _______________

WHOM MAY WE THANK FOR REFERRING YOU? _______________

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _______________

SPOUSE INFORMATION:

HIS/HER NAME _______________ EMPLOYER _______________

WORK PHONE_______________ BIRTHDATE _______________

SOCIAL SECURITY NUMBER: _______________ DRIVERS LICENSE# _______________

ORTHODONTIC COVERAGE? ❑ YES ❑NO DENTAL COVERAGE? ❑ YES ❑ NO

INSURANCE CARRIER_______________ PHONE _______________

ADDRESS_______________ GROUP/POLICY # _______________

SECONDARY INSURANCE CARRIER _______________ PHONE _______________

ADDRESS_______________ GROUP/POLICY # _______________

IF INSURANCE IS ACCEPTED, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AND ALSO RESPONSIBLE FOR PAYING ANY CO-PAYMENT AND DEDUCTIBLES THAT MY INSURANCE DOES NOT COVER. I HEREBY AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. AND I ASSIGN DIRECTLY TO LYONS ORTHODONTICS ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I FURTHER AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS, WHETHER MANUAL OR ELECTRIC.

SIGNATURE_______________ DATE _______________

PLEASE SEE REVERSE SIDE

DENTAL/MEDICAL HISTORY

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

____

____

HAVE YOU EVER BEEN EVALUATED OR HAD ORTHODONTIC CARE BEFORE?
❑ YES ❑ NO

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH, TEETH OR CHIN?
❑ YES ❑ NO

HAVE YOU EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK? ❑ YES ❑ NO

HAVE YOU EVER HAD ANY PAIN/TENDERNESS IN YOUR JAW JOINT (TMJ/TMD)?
❑ YES ❑ NO

DO YOU HAVE ANY MISSING OR EXTRA PERMANENT TEETH?
❑ YES ❑ NO

DO YOU STILL HAVE WISDOM TEETH? ❑ YES ❑ NO

YOUR CURRENT DENTAL HEALTH? ❑ GOOD ❑ FAIR ❑ POOR

DO YOU HAVE ANY SPEECH PROBLEMS? ❑ YES ❑ NO

DO YOU GENERALLY BREATHE THROUGH YOUR MOUTH?

IF YES, ❑ YES ❑ NO

WHILE AWAKE? ❑ YES ❑ NO WHILE ASLEEP? ❑ YES ❑ NO

DO YOU HAVE A PERSONAL PHYSICIAN? ❑ YES ❑ NO

PHYSICIAN'S NAME ____

PHONE_______________________ DATE OF LAST VISIT_______________

YOUR CURRENT PHYSICAL HEALTH? ❑ GOOD ❑ FAIR ❑ POOR

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? Please Explain__________

____

HAVE YOU HAD ANY METAL RODS, PINS, OR IMPLANTS? ❑ YES ❑ NO

HAVE YOU EVER TAKEN PHEN-FEN? (Also known as Redux or Pondimin) ❑ YES ❑ NO

IF SO, WHEN? ____

FOR WOMEN; ARE YOU TAKING BIRTH CONTROL PILLS? ❑ YES ❑ NO

ARE YOU PREGNANT? ❑ YES ❑ NO

ARE YOU NURSING? ❑ YES ❑ NO

PLEASE LIST ALL DRUGS (PRESCRIPTION & OVER-THE-COUNTER) THAT YOU ARE CURRENTLY TAKING:

____

____

LIST ALL DRUGS/THINGS YOU ARE ALLERGIC TO:

____

____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N		Y N		Y N		Y N			
❑ ❑	ABNORMAL BLEEDING	❑ ❑	DIABETES	❑ ❑	HIV+	❑ ❑	RHEUMATIC FEVER	❑ ❑	VENEREAL DISEASE
❑ ❑	ALCOHOL/DRUG ABUSE	❑ ❑	EPILEPSY	❑ ❑	KIDNEY PROBLEMS	❑ ❑	SCARLET FEVER	❑ ❑	ANY OTHER MEDICAL CONDITIONS NOT LISTED ON THIS FORM?
❑ ❑	ANEMIA	❑ ❑	EYE PROBLEMS	❑ ❑	LEUKEMIA	❑ ❑	SEIZURES		
❑ ❑	ASTHMA	❑ ❑	FAINTING	❑ ❑	LIVER DISEASE	❑ ❑	SHINGLES		
❑ ❑	ARTHRITIS	❑ ❑	GLAUCOMA	❑ ❑	LOW BLOOD PRESSURE	❑ ❑	SICKLE CELL ANEMIA		________________
❑ ❑	BLOOD TRANSFUSION	❑ ❑	HEART DEFECT	❑ ❑	LUPUS	❑ ❑	SINUS PROBLEMS		
❑ ❑	CANCER	❑ ❑	HEART ATTACK	❑ ❑	MITRAL VALVE PROLAPSE	❑ ❑	STROKE		________________
❑ ❑	COLITIS	❑ ❑	HEPATITIS - TYPE___	❑ ❑	PACEMAKER	❑ ❑	THYROID		
❑ ❑	CHRONIC SINUS	❑ ❑	HERPES	❑ ❑	PSYCHIATRIC DISORDER	❑ ❑	TOBACCO USAGE		
❑ ❑	CONVULSIONS	❑ ❑	HIGH BLOOD PRESSURE	❑ ❑	RADIATION TREATMENT	❑ ❑	TUBERCULOSIS		

ARE YOU HAPPY WITH THE WAY YOUR SMILE LOOKS? ❑ YES ❑ NO

IF NOT, WHAT WOULD YOU CHANGE? ____

____

OUR OFFICE IS HIPPA COMPLIANT AND IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

I UNDERSTAND THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND THAT IT IS MY RESPONSIBILITY TO INFORM LYONS ORTHODONTICS OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL/ORTHODONTIC SERVICES THAT I MAY NEED.

SIGNATURE _______________________________________ DATE ____________________

I HAVE VERBALLY REVIEWED THE MEDICAL/DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

SIGNATURE OF DENTIST ___________________________ COMMENTS ___________________________

____

MEDICAL HISTORY UPDATE

RECALL REVIEW

1. SIGNATURE: _______________________________________ DATE: ______________

2. SIGNATURE: _______________________________________ DATE: ______________

3. SIGNATURE: _______________________________________ DATE: ______________