WELCOME

Lyons Orthodontics

Pride in Every Smile

TODAY'S DATE: _____

CHILD'S NAME _____ NICKNAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ SCHOOL _____ GRADE _____

AGE _____ BIRTHDATE _____ ❑ MALE ❑ FEMALE SOCIAL SECURITY NUMBER: _____

E-MAIL ADDRESS: _____ HOBBIES/SPORTS: _____

WHO IS ACCOMPANYING THE CHILD TODAY? NAME _____ RELATION _____

DO YOU HAVE CUSTODY OF THIS CHILD? ❑ YES ❑ NO WHOM MAY WE THANK FOR REFERRING YOU? _____

RELATIVE OR FRIEND NOT LIVING WITH YOU: NAME _____ PHONE _____

GENERAL DENTIST _____ PHONE _____ DATE OF LAST VISIT _____

WHO IS RESPONSIBLE FOR ACCOUNT? _____ PARENT'S MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑PARTNERED ❑DIVORCED ❑SEPARATED ❑WIDOWED

❑ FATHER ❑ STEP FATHER ❑ GUARDIAN

NAME _____ SSN# _____ BIRTHDATE _____ DRIVER'S LICENSE _____ STATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

EMPLOYER _____ HOW LONG _____ WORK PHONE _____

INSURANCE CARRIER _____ PHONE _____

ADDRESS _____ GROUP/POLICY # _____

❑ MOTHER ❑ STEP MOTHER ❑ GUARDIAN

NAME _____ SSN# _____ BIRTHDATE _____ DRIVER'S LICENSE _____ STATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

EMPLOYER _____ HOW LONG _____ WORK PHONE _____

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?

_____

_____

HAS YOUR CHILD EVER BEEN EVALUATED OR HAD ORTHODONTIC CARE BEFORE? ❑ YES ❑ NO

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

DOES YOUR CHILD REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? ❑ YES ❑ NO

HAVE ADENOIDS OR TONSILS BEEN REMOVED? ❑ YES ❑ NO

DOES YOUR CHILD HAVE ANY MISSING OR EXTRA PERMANENT TEETH? ❑ YES ❑ NO

HAS YOUR CHILD EVER HAD ANY PAIN/TENDERNESS IN THEIR JAW JOINT? ❑ YES ❑ NO

DOES YOUR CHILD BRUSH THEIR TEETH DAILY? ❑ YES ❑ NO

DOES YOUR CHILD FLOSS THEIR TEETH DAILY? ❑ YES ❑ NO

CHILD'S PHYSICIAN _____

PHONE_____ DATE OF LAST VISIT_____

IS YOUR CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? ❑ YES ❑ NO

HAS PUBERTY BEGUN? ❑ YES ❑ NO

HAS MENSTRUATION BEGUN? ❑ YES ❑ NO

PLEASE DESCRIBE YOUR CHILD'S CURRENT PHYSICAL CONDITION?

❑ GOOD ❑ FAIR ❑ POOR

PLEASE LIST ALL DRUGS THAT YOUR CHILD IS CURRENTLY TAKING:

_____

_____

LIST ALL DRUGS/THINGS YOUR CHILD IS ALLERGIC TO:

_____

_____

_____

ALLERGIC TO: ❑ LATEX ❑ NICKEL/METALS ❑ PLASTIC

ARE YOUR CHILD'S IMMUNIZATIONS CURRENT? ❑ YES ❑ NO

HAS YOUR CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

Y	N		Y	N		Y	N		Y	N		Y	N	
❑	❑	ADD/ADHD	❑	❑	CONVULSIONS	❑	❑	HIV+	❑	❑	PREGNANT/NURSING	❑	❑	THYROID
❑	❑	ANEMIA	❑	❑	DIABETES	❑	❑	HYPERACTIVITY	❑	❑	PSYCHIATRIC DISORDER	❑	❑	TOBACCO USAGE
❑	❑	ASTHMA	❑	❑	EPILEPSY	❑	❑	JAW PROBLEMS	❑	❑	RHEUMATIC FEVER	❑	❑	TUBERCULOSIS
❑	❑	AUTISM	❑	❑	EYE PROBLEMS	❑	❑	KIDNEY	❑	❑	SCARLET FEVER	❑	❑	VENEREAL DISEASE
❑	❑	BLADDER	❑	❑	FAINTING	❑	❑	LEUKEMIA	❑	❑	SICKLE CELL ANEMIA	❑	❑	ANY OTHER MEDICAL CONDITIONS NOT LISTED ON THIS FORM?
❑	❑	CANCER	❑	❑	HEARING	❑	❑	LIVER	❑	❑	SCOLIOSIS			
❑	❑	CEREBRAL PALSY	❑	❑	HEART	❑	❑	MEASLES	❑	❑	SORE THROATS (FREQUENT)			
❑	❑	CHICKEN POX	❑	❑	HEPATITIS - TYPE___	❑	❑	MONONUCLEOSIS	❑	❑	SPEECH THERAPY			_____
❑	❑	CHRONIC SINUS	❑	❑	HEMOPHILIA	❑	❑	MUMPS	❑	❑	TETANUS			_____

DOES/DID YOUR CHILD EXPERIENCE ANY OF THE FOLLOWING?

❑ BREAST FED ❑ CLENCHING/GRINDING TEETH ❑ LIP SUCKING/BITING ❑ MOUTH BREATHER ❑ NAIL BITING
❑ NURSING BOTTLE HABITS ❑ SPEECH PROBLEMS ❑ THUMB/FINGER SUCKING ❑ TONGUE THRUST ❑ USED PACIFIER

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES, OR ANY OTHER INFORMATION WE SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED:_____

_____

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 CHILD'S MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL/ORTHODONTIC SERVICES THAT MY CHILD MAY NEED.

SIGNATURE _____ DATE _____

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

SIGNATURE OF DENTIST _____ COMMENTS _____

_____

MEDICAL HISTORY UPDATE

RECALL REVIEW

1. PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

2. PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

3. PARENT/GUARDIAN SIGNATURE: _____ DATE: _____