Dr. P. A. Lyons, D. D. S.
Cosmetic and General Denistry

About You

Today's Date: ___/___/_____

Email Address: _____

Name: _____
Last First MI Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthdate: ___/___/__ Age: ___ SS#: ___-___-____
Single Married Divorced Widowed Seperated

Home Address: _____ Apt/Condo# _____

_____
City State Zip

Hm# ( ) _____ Pager/Cell# ( ) _____

Wk# ( ) _____ DL# ( ) _____

How do you prefer to confirm your appointment?

_____

Employer: _____

Employer Address: _____

How long there? _____ Present Position: _____

How did you find out about our office? _____

_____

Do you have any children? Yes No

Ages: _____

Spouse Information

His/Her Name: _____ SS#: ____-___-_____

Home#: ( ) ____Cell# : ( ) _____DL#:( ) _____

Birth Date: ___/____/____ Employer: _____

Present Position: _____Wk# ( ) _____ Ext. ___

Person Ultimately responsible for account should be the person providing this information

Name:

Home#: ( ) _____Cell# : ( ) _____

Wk#: ( ) _____

SS#: ___ - ___ - ____ DL#: _____

Employer: _____

Payment Method : Cash Check Credit Card

Enter Card # _____ Exp Date: ___/___

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name : _____Relation: _____

Home#: ( ) _____ Cell# : ( ) _____

Wk#: ( ) _____

Dental Insurance

Primary Dental insurance:

Insured Name : _____ Relation: _____

Insured SS#: ____-___-_____ DOB: ___/___/_____

Insured employer: _____

Insurance Company Name:_____

Group#: _____

Insurance Company Phone: ( ) _____

Secondary Dental insurance:

Insured Name: _____Relation: _____

Insured SS#: ____-___-_____ DOB: ___/___/_____

Insured employer: _____

Insurance Company Name: _____

Group# _____

Insurance Company Phone: ( ) _____

_____ I here by authorize assignment of my insurance initials rights and benefits directly to the provider for the services rendered. I full understand I am solely responsible for any balance not paid by my insurance company.

Missed Appointments:

Keeping scheduled appointments allows us to provide optimal care for our patients and to monitor progress in a timely manner. As a courtesy to our staff, we require a 24 hour notice in case of cancellation. However after THREE changes in scheduling, we reserve the right to charge a $50.00 rescheduling fee for every 30 minutes of appointment time scheduled. Repeated rescheduling or no shows results in serious delay in treatment for you and other patients needing to be seen. SAME DAY APPOINTMENTS may have to be enforced.

Medical History

Do you have personal physician? ☐ Yes ☐ No
Physicians Name: _____
Wk# ( ) _____ Date of Last Visit: ___/___/_____
Pharmacy Name: _____ Pharmacy Phone# ( ) _____
You current physical health is : ☐ Good ☐ Poor ☐ Fair
Have you ever taken Phen-fen?(Also known as Redux or pondimin) If so, when? _____
Have you ever taken Fosamax? If so, when? _____
For Woman?: Are taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No week#: _____
Are you nursing? ☐ Yes ☐ No
Are you taking any following medications?
☐ Nerve Pill ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers
☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Others, Please list:
Are you taking any prescription/over- the-counter or supplement drugs? ☐ Yes ☐ No
If yes please list 1. _____ 2. _____
3. _____ 4. _____ 5. _____

Do you have or have you had any of the following diseases, medical conditions of procedures?

☐ Anemia
☐ Asthma
☐ Artificial Bones/Joints/Valves
☐ Arthritis/Rheumatism
☐ Back problems
☐ Blood Transfusion
☐ Cancer / Chemotherapy
☐ Chest Pains
☐ Congenital Heart defect
☐ Cosmetic Surgery
☐ Diabetes/Hypoglycemia
☐ Difficulty Breathing
☐ Drug/Alcohol Abuse
☐ Emphysema
☐ Epilepsy/Seizures/Fainting spells
☐ Fever Blisters/ Herpes
☐ Frequent Neck Pain
☐ Glaucoma
☐ Heart Attack/ Stroke
☐ Heart Disease
☐ High Blood pressure / low
☐ Heart Surgery/Pacemaker
☐ Hemophilia/Abnormal Bleeding
☐ Hepatitis A / B / C
☐ HIV +/Aids
☐ Kidney Problems
☐ Mitral Valve Prolapsed
☐ Nervousness
☐ Psychiatric Problems
☐ Radiation/ Cobalt Treatments
☐ Respiratory Problems
☐ Rheumatic / Scarlet Fever
☐ Migraines/Frequent Headaches
☐ Shingles
☐ Sickle Cell Disease/Traits
☐ Sinus Problems
☐ Tuberculosis (TB)
☐ Thyroid Condition
☐ Ulcers/ Colitis
☐ Venereal Disease
☐ Heart Murmur
☐ Cholesterol

Please list any other surgeries or medical conditions you have or ever had:

Are you allergic to any of the following:

☐ Aspirin ☐ Codeine ☐ Dental Anesthetics ☐ Erythromycin
☐ Jewelery/Metals ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Tetracycline
☐ Other

Please list any other drugs/ materials that you are allergic to:_____
_____

Dental History

Reasons for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes How long? _____

Please indicate of the following problems:

☐ Discomfort, clicking or popping in jaw
☐ Red, swollen or bleeding gums
☐ Teeth grinding
☐ Sensitive teeth to cold or hot water
☐ Bad Breath
☐ Broken tooth
☐ Biting nails/pen/pencil, Etc
☐ Lost/ Broken Filling
☐ Stained teeth
☐ Locking Jaw
☐ Ringing in ears
☐ Blisters/ Sores in or around the mouth
☐ Lip or cheek biting
☐ Other: _____

Previous Dentist Name: _____ Phone# ( ) _____

Last dental exam: ___/___/_____ Last dental X-rays: ___/___/_____

Times a day you brush? ___ Times day you floss? ___
Type of brush? ☐ Soft ☐ Medium ☐ Hard

How do you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Have you ever had a serious/ difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had a gum treatment or been diagnosed with periodontal disease?
☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No If yes, when? _____

Do you use any tobacco products? ☐ Yes ☐ No

We invite you to discuss with us any questions regarding our services. The best dental health services are base on friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid in 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fess, collection agency fees, interest charges and any other expenses incurred in collecting in your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I authorize Dr.Lyons and /or staff to take photos of my care and treatment, which may be used for the advancement and educational viewing by other dentists, staff or patients. Dr. Lyons and her staff cannot reveal my identification without my permission. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: ____/_____/_____

☐ Adult Patient ☐ Parent or Guardian