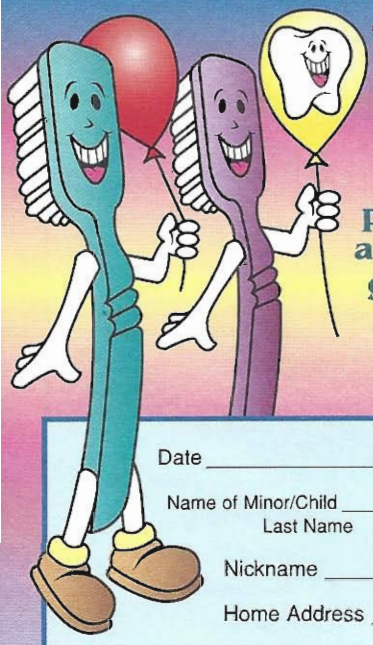
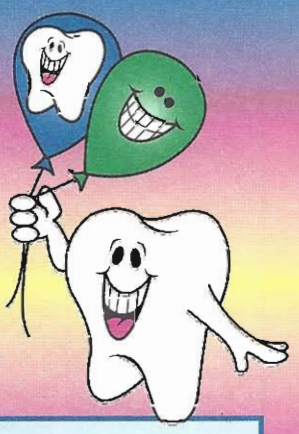


Welcome!



We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

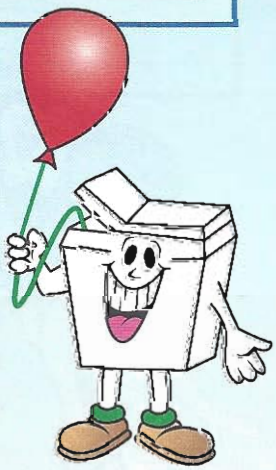
Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐



Please Complete Both Sides

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO	
Is Minor/Child under care of physician now?	☐	☐	Medications _____
Receiving any medication or drugs?	☐	☐	_____
Ever been hospitalized?	☐	☐	_____
Ever had surgery?	☐	☐	Allergies _____
Is there excessive bleeding when cut?	☐	☐	_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

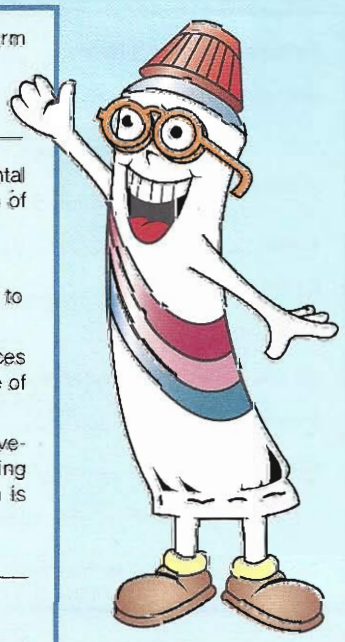
I certify that my dependent(s) is covered by insurance with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Parent, Guardian or Personal Representative — Relationship to Patient



UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

Office Policy of Lyons Family Dentistry

806 Farnsworth Avenue Bordentown, New Jersey 08505 609-298-8309

Our office mission is to make our patients feel and look their very best through excellent dental care provided by our team.

_____ 1. **Treatment Area:** No one besides the patient will be allowed in the treatment room unless absolutely necessary. This is required by safety regulations.

Cell phone use in the operatories is prohibited due to possible interference with our equipment.

_____ 2. **Appointments:** This time is reserved especially for you. We value your time and we ask the same in return. Any change in this appointment affects many people. Therefore, we ask you to please provide us with 24 hours notice if you are unable to keep your appointment.

_____ 3. **Financial Responsibility:** As a courtesy, we will submit your insurance claims. You are responsible for your estimated co-pay at the time of service. Any remaining portion unpaid by insurance will become your obligation.

Please mark which method of payment you will be using:
Cash _____ Checks _____ Credit Cards _____

Interest free payment plan: Care Credit_____

Returned checks: An assessment fee of $50 will be made for a returned check, plus a bank fee of $15. A cash or credit card payment will be expected before another appointment can be scheduled.

_____ 4. **Courtesy:** Senior patients without insurance will receive a 10% courtesy.

_____ 5. **Right of Access:** All requests for records will be dealt with promptly at no charge.

_____ 6. **Consent for Treatment:** For routine dental x-rays, exams, perio charting, and cleanings, the undersigned hereby consents to examination and treatment of the patient by members of the dental staff of Alina E. Lyons, D.M.D., P.A., Family Dentistry to preserve or improve the patient's health status.

_____ 7. **Authorization to Release Information:** I hereby authorize the dental group to release information and signature on file concerning the examination and treatment of the patient to any insurance company requesting information for the purpose of determining eligibility of insurance to Alina E. Lyons, D.M.D., P.A., Family Dentistry.

Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Other Individuals Allowed Access To My Records

Spouse_____

Mother_____

Father_____

Son/Daughter_____

Significant Other_____

Other_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

SMILE ANALYSIS

1. On a scale of 1 (least) to 10 (most), please mark:

How much do you like your smile?

1 2 3 4 5 6 7 8 9 10

How much do you like the color of your teeth?

1 2 3 4 5 6 7 8 9 10

How much do you like the position of your teeth?

1 2 3 4 5 6 7 8 9 10

2. What would you like to change about your smile?

Notes:

Midline: Upper Lower

Spaces:

Crowding:

Crossbite:

Treatment Plan Recommendation:

Please help us serve you better by telling us how you heard about us.
Please check all that apply.

Family Member	☐	Friend	☐
Spouse	☐	Neighbor	☐
Mother	☐	Aquaintance	☐
Father	☐	Co-worker	☐
Sibling	☐	Parent at school	☐
Child	☐	Parent at day care	☐
Physician	☐	Facebook	☐
Dentist	☐	Twitter	☐
Doctor	☐	Linked-In	☐
Advertisment	☐	Website	☐
Our Town	☐	Google	☐
Burlington County Times	☐		

Other, please specify: _____

Name: _____ Date:_____