Lyons Family Dentistry

lyonsfamilydentistry.com
lyonsdentistry@verizon.net
806 Farnsworth Avenue • Bordentown, NJ 08505

(609)298-8309

WELCOME

Thank you for trusting us with your dental care.We promise to do our best to provide you with the finest care available.

PATIENT INFORMATION

Chart#: ______________
FOR OFFICE USE ONLY

Patient Name: ______________ Last ______________ First ____ MI

______________ Preferred Name

Title: ______________ Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______________

SS#: ___-__-____

Prev. Visit: ______________

Email Address: ______________

Best time to call: ______________

Phone: ______________ Home ______________ Mobile ______________ Work ________ Ext

______________ Fax ______________ Other

Address: ______________ Address 1

______________ Address 2

______________ City ________ State _____-____ Zip Code

Whom may we thank for referring you to our practice?

- ☐ Google
- ☐ Googled Sedation
- ☐ Googled Dentist near me
- ☐ Billboard on Rt.130
- ☐ Billboard on Rt.206
- ☐ Delta Dental
- ☐ Cigna
- ☐ MetLife
- ☐ Facebook
- ☐ Instagram
- ☐ Internet
- ☐ Twitter
- ☐ Newspaper
- ☐ School
- ☐ Work
- ☐ Other (name below):

Name of person we may thank for referring you to our Practice

____

Person to contact in case of an emergency:

____

____

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name:

Last First MI

Preferred Name

Title:

Gender:

Mr/Ms/Mrs/etc

◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:

Email Address:

Phone:

Home Mobile Work Ext

Best time to call:

Address:

Address 1

Address 2

City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name:

Phone:

Employer Address:

Address 1

Address 2

City

State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #:

Group #:

Insured's Address:

Address 1

Address 2

City

State   Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State   Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State   Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured:

Last

First   MI

Insured's Birth Date:

ID#   **Group #:**

Insured's Address:

Address 1

Address 2

City

State   Zip Code

Insured's Employer Name:

____

Employer Address:

____
Address 1

____
Address 2

____
City

_____ _____-_____
State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

____

Insurance Address:

____
Address 1

____
Address 2

____
City

_____ _____-_____
State Zip Code

Dental History

Reason for today's Visit

____

____

Date of last dental care: __________

Date of last dental x-rays: __________

Former Dentist: ______________

Check if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding your teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ______________

How often do you brush? ______________

Medical History

Check if you have had any of the following:

☐ *Allergy	☐ *Allergy-Other	☐ *Pre-Med -	☐ *Pre-Med -
☐ Allergy - Aspirin	☐ Allergy - Barbituate	☐ Allergy - Codeine	☐ Allergy - Erythro
☐ Allergy - Latex	☐ Allergy - Penicillin	☐ Allergy - Percocet	☐ Allergy - Sulfa
☐ Allergy Amoxicillin	☐ Allergy- Augmentin	☐ Allergy Bactrim	☐ Allergy clindomycin
☐ Allergy- Flagyl	☐ Allergy Keflex	☐ Allergy -Local anest	☐ Allergy- metals
☐ Arthritis	☐ Artificial Joints	☐ Asthma	☐ Blood Disease
☐ Cancer	☐ Cipro	☐ codeine	☐ Diabetes
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ high cholesterol	☐ HIV	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders	☐ Mitral Valve Prolaps
☐ Morphine	☐ -mycins	☐ Nervous Disorders	☐ No EPI
☐ Pacemaker	☐ Pregnancy	☐ Pre-Med	☐ Pre-Med Amoxicillin
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Stroke
☐ Tuberculosis	☐ Ulcers	☐ Venereal Disease	

Please list any medications you are currently taking, one medication per line:

____

____

____

____

Consent for Services

As a condition of treatment by this office all treatment must be paid in full upon scheduling your treatment appointment. The practice depends upon reimbursement from patients for the costs incurred in their care.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

To the best of my knowledge, the above information is complete and correct, I understand that it is my responsibility to inform Lyons Family Dentistry, if I or my minor child ever have a change in health. I certify that I, and/or my dependent(s) have insurance coverage with the insurance company listed above and assign directly to Lyons Family Dentistry 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 submissions.

The above named dentist may use my 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.

☐ ***I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

Signature ____

Date
Relationship to Patient:

Response Date: ___________