

**MICHAEL S. LYONS, DDS, MS, INC**

300 E. Yorba Linda Blvd Ste. H  
Placentia CA 92870  
714-993-3500

Date \_\_\_\_\_

**Patient Information**

Patient's name \_\_\_\_\_  
Last First Middle Nickname

Residence \_\_\_\_\_  
Street City State Zip

CELL Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Dentist \_\_\_\_\_ Last visit \_\_\_\_\_

If patient is a minor, give parent or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ e-mail address \_\_\_\_\_

Please tell us how you prefer to be contacted  e-mail  Text # \_\_\_\_\_  Telephone (Cell)

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Yrs. at this Employer \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Yrs. at this Employer \_\_\_\_\_

**Insurance Information**

Policy Holder's name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union Local # \_\_\_\_\_

Insurance Co. address \_\_\_\_\_ Ins. Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Policyholder Birth Date \_\_\_\_\_

Do you have dual coverage?  Yes  No If yes, fill in below:

Policy Holder's name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union Local # \_\_\_\_\_

Insurance Co. address \_\_\_\_\_ Ins. Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Policyholder Birth Date \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## Patient Information

Patient's height \_\_\_\_\_ Weight \_\_\_\_\_ Father's height \_\_\_\_\_ Mother's height \_\_\_\_\_

Please describe any specific issues about your teeth or smile that you would like to address: \_\_\_\_\_

Names of other family members previously examined in this office: \_\_\_\_\_

Have you ever had any serious problems associated with previous dental treatment? If yes, please explain \_\_\_\_\_

## Health History

Has the patient had any of the following?

Baby teeth removed by dentist	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Major accident involving head, face or trauma to teeth	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If so, when? _____		
Describe _____		
Seen by dentist after trauma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Habits such as		
Nail biting	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Thumb/finger sucking	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Until what age _____		
Lip or cheek biting	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Discomfort with bite or difficulty chewing	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Speech problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty opening mouth	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Noises or discomfort in the jaw joint	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Jaw locking	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Clenching:       Awake   Asleep	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Grinding of teeth:   Awake   Asleep	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent headaches due to clenching or grinding	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sinus problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty breathing through nose       Awake   Asleep	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cold sores or fever blisters in mouth	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hay fever, asthma or other allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fen Phen diet	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Drug Allergies		
Antibiotics _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Latex	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Metals (nickel, tin, silver)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis or lung disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic fever, heart murmur, heart surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Artificial joint or heart valve	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you require pre-medication prior to dental procedures?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Abnormal blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy, seizures or convulsions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Last episode _____		
Venereal disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HIV positive/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Overnight hospitalization (other than childbirth)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you taking any medications?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please list _____		
If female:		
Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medications for osteoporosis or breast cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
List _____		

I acknowledge that all of the above is true to the best of my knowledge, and grant permission for this information to be shared with my insurance company and other health care providers. I understand that x-rays and/or photographs of the patient may be taken.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Office Use Only

Reviewed by \_\_\_\_\_

DDS	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C
MS	<input type="checkbox"/> M	<input type="checkbox"/> S	
Res	<input type="checkbox"/> 5+	<input type="checkbox"/> 1-5	<input type="checkbox"/> <1
Emp	<input type="checkbox"/> 5+	<input type="checkbox"/> 1-5	<input type="checkbox"/> <1
RPAge	<input type="checkbox"/> >30	<input type="checkbox"/> 20-30	<input type="checkbox"/> <20
Hx	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C
	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C