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

Drug Allergies		
Antibiotics _____	Yes☐	No☐
Latex	Yes☐	No☐
Metals (nickel, tin, silver)	Yes☐	No☐
Diabetes	Yes☐	No☐
Hepatitis	Yes☐	No☐
Anemia	Yes☐	No☐
Tuberculosis or lung disease	Yes☐	No☐
Rheumatic fever, heart murmur, heart surgery	Yes☐	No☐
Artificial joint or heart valve	Yes☐	No☐
Do you require pre-medication prior to dental procedures?	Yes☐	No☐
Abnormal blood pressure	Yes☐	No☐
Epilepsy, seizures or convulsions	Yes☐	No☐
Last episode _____		
Venereal disease	Yes☐	No☐
HIV positive/AIDS	Yes☐	No☐
Overnight hospitalization (other than childbirth)	Yes☐	No☐
Are you taking any medications?	Yes☐	No☐
Please list _____		
_____		
If female:		
Are you pregnant?	Yes☐	No☐
Medications for osteoporosis or breast cancer	Yes☐	No☐
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	☐A	☐B	☐C
MS	☐M	☐S	
Res	☐5+	☐1-5	☐<1
Emp	☐5+	☐1-5	☐<1
RPAge	☐>30	☐20-30	☐<20
Hx	☐A	☐B	☐C
	☐A	☐B	☐C

FAMILY CARE PROGRAM

We are looking forward to meeting you at your upcoming initial evaluation.

We believe that many orthodontic problems can be corrected or minimized at an early age. For that reason we like to see our patients for their first examinations when the first set of permanent teeth is erupted, usually at the age of eight. At times, an observation period is indicated before more comprehensive treatment can be started to achieve maximum treatment benefits.

This is your opportunity to *automatically* enroll any other children for a complimentary, no-obligation orthodontic evaluation at the time of their 8th birthday. A brief screening examination includes a written report to the child's family dentist with Dr. Lyons' findings and recommendations.

Please list below any siblings that you would like to have examined sometime around their 8th birthday:

Name:_____ Birthdate:_____

Name:_____ Birthdate:_____

Name:_____ Birthdate:_____

Name:_____ Birthdate:_____

We treat parents, too! As a family care provider we welcome family members of ALL ages. If any other member of your family has an orthodontic concern that may not have been addressed at an earlier age we encourage them to take the opportunity to seek out their options in orthodontics as well. We will be happy to schedule an appointment for them to answer any questions they may have. When any additional family member begins treatment there will be a $200.00 fee reduction in their total treatment fee.

Name:_____ Concern:_____

Name:_____ Concern:_____

We look forward to working with you and assessing your family's orthodontic needs. Thank you and welcome to our practice!

Dr. Lyons and Team

Please tell us about your smile

Your name: _____

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (circle all that apply):

Too small or short?	No	Yes
Too large or long?	No	Yes
Crooked or crowded?	No	Yes
Misshaped (uneven/pointed)?	No	Yes
Discolored?	No	Yes

Do you feel that your teeth stick out too much ("Buck teeth")? No Yes

Are there spaces between your teeth that you do not like? No Yes

Is there too much gum tissue showing when you smile? No Yes

Has there been previous orthodontic treatment? No Yes

If so, when and by whom? _____

Are there other dental issues not listed above that you would like to discuss or have treated?

No Yes (explain) _____

_____

Signature _____ **Date** _____

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _____, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____

_____

_____