LYON
MAISON D'ART DENTAIRE

PATIENT INFORMATION

PATIENT INFORMATION

Patient First Name: | Patient Last Name: | DOB: | SS#/SIN | Patient #

Address | City | State | Zip

Email. | Home Phone No. | Cell

Check Appropriate Box: | If Student, Name of School/College

City: | State: | Patient or Parent/Guardian's Employer | Work Phone:

Address | City | State | Zip

Spouse or Parent/Guardian's Name | Employer | Work Phone

Whom may we thank for referring you? | Person to contact in case of emergency | Phone:

RESPONSIBLE PARTY

Name of Person Responsible for this account | Relationship to Patient | Address | Home Phone

Email | Cell Phone | Driver's License # | Birth Date | Financial Institution

Employer | Work Phone | SS#/SIN

Is this person currently a patient in our office?

- ○ Yes
- ○ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

- ☐ Cash
- ☐ Personal Check
- ☐ Credit Card
- ☐ VISA
- ☐ Master Card
- ☐ I Wish to discuss the office's payment policy.

INSURANCE INFORMATION

Name of Insured | Relationship to Patient | Birth Date | SS#/SIN | Date Employed

Name of Employer | Union or Local # | Work Phone

Address of Employer | City | State | Zip

Insurance Company | Group # | Policy/ID #

Ins. Co. Address | City | State | Zip

How much is your deductible? | How much have you used? | Max. annual benefit

DO YOU HAVE ANY ADDITIONAL INSURANCE

- ○ Yes
- ○ No

IF YES, COMPLETE THE FOLLOWING

Name of Insured | Relationship to Patient | Birth Date | SS#/SIN | Date Employed

Name of Employer | Union or Local # | Work Phone

Address of Employer | City | State | Zip

Insurance Company | Group # | Policy/ID #

Ins. Co. Address | City | State | Zip

How much is your deductible? | How much have you used? | Max. annual benefit

Patient Signature:

Sign

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PATIENT MEDICAL HISTORY

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Patient First Name: _____ Patient Last Name: _____ Birth Date: _____

Physician: _____ Phone: _____ Date of Last Exam: _____

1. Are you under medical treatment now?

○ Yes
○ No

If yes, please explain

_____

If yes, what medication(s) are you taking?

_____

2. Have you ever been hospitalized for any surgical operation or following?

○ Yes
○ No

3. Are you taking any medication(s) including non-prescription medicine?

○ Yes
○ No

	Yes	No
4. Have you ever taken Fen-Phen/Redux?	○	○
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	○	○
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 Hour?	○	○
7. Do you use tobacco?	○	○
8. Do you use controlled substances?	○	○

9. Do you have or have you had any of the following?

☐ Asthma
☐ Cancer
☐ Diabetes
☐ Heart Murmur
☐ Heart Trouble
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Rheumatic Fever
☐ Stroke

☐ Heart Attack
☐ Swollen Ankles
☐ Fainting/Seizure
☐ Epilepsy/Convulsions
☐ Leukaemia
☐ Low Blood Pressure
☐ Thyroid Problem
☐ AIDS or HIV Infection
☐ Heart Disease
☐ Angina
☐ Cardiac Pacemaker
☐ Frequently Tired
☐ Anemia
☐ Arthritis
☐ Joint Replacement or Implant
☐ Hepatitis/Jaundice
☐ Sexually Transmitted Disease
☐ Stomach Troubles/Ulcers
☐ Chest Pains
☐ Easily Winded
☐ Hay Fever/Allergies
☐ Tuberculosis
☐ Radiation Therapy
☐ Glaucoma
☐ Recent Weight Loss
☐ Respiratory Problems
☐ Mitral Valve Prolapse
☐ Cardiac Pacemaker

10. Are you wearing contact lenses?

○ Yes
○ No

11. Are you allergic to or have you had any reactions to the following?

☐ Anesthetic
☐ Aspirin
☐ Codeine
☐ Ibuprofen
☐ Iodine
☐ Latex
☐ Penicillin
☐ Sulfa

☐ Barbiturates
☐ Latex Rubber
☐ Any Metals (e.g. nickel, mercury, etc.)
☐ Sedatives

(please list)

12. Do you have persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?

○ Yes

○ No

Name of Previous Dentist and Location

Date of Last Exam

	Yes	No
8. Do you frequent headaches?	○	○
9. Do you clench or grind your teeth?	○	○
10. Do you bite your lips or cheeks frequently?	○	○
11. Have you ever had any difficult extractions in the past?	○	○
12. Have you ever had any prolonged bleeding following extractions?	○	○
13. Have you had any orthodontic treatment?	○	○
14. Do you wear dentures or partials?	○	○

13. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	○	○
b) Are you nursing?	○	○
c) Are you taking oral contraceptives?	○	○

	Yes	No
1. Do your gums bleed while brushing or flossing?	○	○
2. Are your teeth sensitive to hot or cold liquids/foods?	○	○
3. Are your teeth sensitive to sweet or sour liquids/foods?	○	○
4. Do you feel pain to any of your teeth?	○	○
5. Do you have any sores or limps in or near your mouth?	○	○
6. Have you had any head, neck or jaw injuries?	○	○
7. Have you ever experienced any of the following problems in your jaw?	○	○
Clicking	○	○
Pain (joint, ear, side of face)	○	○
Difficulty in opening or closing	○	○
Difficulty in chewing	○	○

If yes, date of placement

	Yes	No
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	○	○
16. Do you like your smile?	○	○

AUTHORIZATION AND RELEASE

☐ I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care, to third-party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

Patient Signature:

Sign