304 Main Street / PO Box 1990
Lyons, CO 80540
303-823-6006
info@Lyons-Dental.com

Lyons Dental New Patient Intake Form

Date: _____

Name: _____ Birthdate: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____

Sex: ☐ M ☐ F Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnership ☐ Minor

Employer or School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse, partner or parent name: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you learn about Lyons Dental or whom may we thank for referring you? _____

Insurance information Insurance company: _____ Phone # _____

Subscriber's Birthdate: _____ Social Security # _____ Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary dental insurance Insurance company: _____ Phone # _____

Lyons Dental reserves the right to not submit for secondary insurance and will provide you with documentation to do this.

Your Social Security # _____ Date of Birth: _____

Group # _____ ID # _____

Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dental history

Reason for today's visit to Lyons Dental: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____

Former dentist's name: _____ Address: _____ City: _____ State: ____ Zip: _____ Phone: _____

Check if you have any problem with the following:

☐ Bad breath ☐ Food collection between certain teeth ☐ Periodontal treatment

☐ Bleeding gums ☐ Grinding teeth ☐ Sensitivity to any of the following: cold, hot, sweets, biting

☐ Clicking or popping jaw ☐ Loose teeth or broken fillings ☐ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Complete other side

Medical History

Your physician: _____ Date of last visit _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? These include combinations of loimin, Adipex, Fastin (brand name of phentermine) Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, give approximate dates: _____

Women: are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking birth control? ☐ Yes ☐ No

Check if you have or have had any of the following:

☐ Anemia	☐ Circulatory problems	☐ Hepatitis	☐ Rheumatic fever
☐ Arthritis, rheumatism	☐ Congenital heart lesions	☐ High blood pressure	☐ Scarlet fever
☐ Artificial heart valves	☐ Diabetes	☐ HIV AIDS	☐ Sexually transmitted disease
☐ Artificial joints, pins, etc.	☐ Epilepsy	☐ Jaw pain	☐ Stroke
☐ Asthma	☐ Fainting	☐ Kidney disease	☐ Swelling of feet or ankles
☐ Bleeding abnormally	☐ Glaucoma	☐ Liver disease	☐ Thyroid problems
☐ Blood disease	☐ Headaches	☐ Mitral valve prolapse	☐ Tobacco use
☐ Cancer	☐ Heart murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical dependency	☐ Heart problems	☐ Radiation treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Hemophilia	☐ Respiratory disease	☐ Ulcer

List medications you are currently taking and the correlating diagnosis: _____

_____

_____

_____

_____

_____

Allergies: _____

_____

_____

Authorization

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 I or my minor child has a change in health.

I certify that I and/or my dependent/s have insurance coverage with _____ and assign directly to Dr. Dennis Johnstone 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 my insurance. I authorize the use of my signature on all insurance submissions.

Dr. Johnstone may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. This consent will continue as long as I am a patient with Dr. Johnstone.

Signature of patient (parent, guardian or person representative) _____ Date: _____

Print name of patient (parent, guardian or person representative) _____ Date: _____

Payment is due at the time of services unless prior arrangements have been made and approved.