FAMILY DENTISTRY
Lyons

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient #_____
SSN #_____
Date_____

PATIENT INFORMATION

Name_____ Birthdate_____ Home Phone (___) ___-_____
Address_____ City_____ State _____ Zip _____
Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Other_____ ☐ Separated ☐ Divorced ☐ Partnered for ___ years
E-mail_____ Cell Phone (___) ___-_____ Home Phone (___) ___-_____
Employer/School_____ Employer/School Phone (___) ___-_____
Address_____ City_____ State _____ Zip_____
Spouse or Parent's Name_____ Employer_____ Work Phone (___) ___-_____
Person to contact in case of emergency_____ Phone (___) ___-_____
How did you hear about us? _____

RESPONSIBLE PARTY

Name of Person
Responsible for Account_____ Relation to Patient_____
Address_____ Home Phone (___) _____
Driver's License #_____ Birthdate_____ Bank_____
Employer_____ Work Phone (___) _____
Currently a patient in our office? ☐ Yes ☐ No E-mail_____ Cell Phone (___) _____

PHARMACY

Pharmacy Name_____ Phone number (____) _____
Address/Location_____

AUTHORIZATION / RELEASE

To the best of my knowledge, the information on this form is complete and correct. I understand that it is my responsibilit to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), hav insurance coverage with _____ and assign directly to Dr. _____ all insuranc benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charge whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-name 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 payable for relate services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Gaurdian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Gaurdian or Personal Representative Relationship to Patient

DENTAL HISTORY

Any concerns you would like addressed? _____

Reason for today's visit_____ Date of last dental care _____

Former Dentist_____ Date of last dental x-rays_____

Address_____

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

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

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

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses/operations? ☐ Yes ☐ No If yes, describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Check if you have any of the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Asthma
- ☐ Back problems
- ☐ Swelling of feet/ankles
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart disease
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia repair
- ☐ High Blood Pressure
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Bleeding abnormally
- ☐ Thyroid problems
- ☐ Tobacco habits
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Venereal disease

Allergies: _____

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information.

These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____ day of _____, 20 ___.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Lyons Family Dentistry
806 Farnsworth Avenue
Bordentown, NJ, 08505

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HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT /LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we ***may not be allowed*** to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** your name | Please ***sign*** your name

_____ _____

Legal Representative | Description of Authority

Your comments regarding Acknowledgements or Consents:

_____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes stepparents, grandparents, and any care takers who can have access to this patient's records):

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA:

- ☐ Cell Phone
- ☐ Home Phone
- ☐ Work Phone
- ☐ Text Message to my Cell Phone
- ☐ E-mail
- ☐ Any of the above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- ☐ Cell Phone
- ☐ Home Phone
- ☐ Work Phone
- ☐ Text Message to my Cell Phone
- ☐ E-mail
- ☐ Any of the above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFORMATION ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

- ☐ Cell Phone
- ☐ E-mail
- ☐ Text Message
- ☐ None of the above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office use only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was an emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign because _____

Other (please describe) _____

_____

Signature of Privacy Officer

OFFICE POLICY OF LYONS FAMILY DENTISTRY

806 Farnsworth Avenue Bordentown, New Jersey, 08505
(609) 298-8309

Our office mission is to make our patients feel and look their very best through excellent dental care provided by our team.

Please read through and initial each line

1. **Treatment Area:**
   No one besides the patient will be allowed in the treatment room unless necessary. This is required by safety regulations. X_____
2. **Cell phone use:**
   No cell phone use in the operatories due to possible interference with our equipment and treatment. X_____
3. **Appointment:**
   We ask you to please provide us with 24 hours' notice if you are unable to keep your appointment. No show to confirmed appointments will be subject to $75 cancellation fee. Emergency cancellations will not be subject to this fee. X_____
4. **Financial Responsibility:**
   As a courtesy, we will submit your insurance claims. You are responsible for your estimated co-pay at the time of service. Any remaining portion unpaid by insurance will become your obligation. Failure to update insurance information PRIOR to appointment may result in paying the full copay. All treatment rendered at our office is an estimate based on the insurance plan selected by the patient.

   Please mark which method of payment you will be using:
   ☐Cash ☐Checks ☐Credit/Debit Cards
   ☐Care Credit

   Returned checks: An assessment fee of $50 will be made for a returned check, plus a bank fee of $15. X_____
5. **Payment Policy:**
   Payment requirement for sedation appointments is 50% of estimated treatment upon scheduling and remaining 50% of estimated to be paid at least 1 week prior.
   Deposit of 50% of proposed treatment estimate of $200 or more is expected at least 1 week prior to appointments. X_____
6. **Courtesy:**
   Patients 65 and older without insurance will receive a 10% courtesy. X_____
7. **Right of Access:**
   All requests for records will be dealt with promptly at no charge. Any outstanding balance must be paid before receiving records. Records may take 1 to 2 weeks to process. X_____
8. **Authorization to Release Information:**
   I hereby authorize Lyons Family Dentistry to release information and signature on file concerning the examination and treatment of the patient to any insurance company requesting information for the purpose of determining eligibility of insurance to Alina Lyons, D.M.D., P.A., Family Dentistry.

Signature: _____ Date: _____