

**Barry D. Lyon, D.D.S. and Associates
Pediatric Dentistry**

Child's Name _____ Age _____ Birthdate _____

Address/Zip _____ Phone _____

Mother's Work Phone _____ Father's Work Phone _____

Complete This Area Only If Information Has Changed

Father's Name _____ Address/Zip _____ Home Phone _____

Employer _____ Occupation _____ Dental Insurance Co. _____

Mother's Name _____ Address/Zip _____ Home Phone _____

Employer _____ Occupation _____ Dental Insurance Co. _____

Name of Child's Physician _____

Is your child being treated by a physician for any condition?.....YES NO _____

Is your child taking any medications (including oral contraceptives).....YES NO _____

Has your child ever been hospitalized?.....YES NO _____

Has your child ever had surgery?.....YES NO _____

Has your child ever had a blood transfusion?.....YES NO _____

Is your child allergic to any medications?.....YES NO _____

Have you ever been told your child has a heart murmur?.....YES NO _____

Please circle if your child has had any of the following:

ADHD AIDS ARC (AIDS Related Complex) Asthma Bleeding Disorders Cancer Diabetes Emotional Problems

Heart Disease Heart Murmur Heart Surgery Hepatitis HIV(+) Liver Disease Mental Retardation Rheumatic Fever

Any condition not listed _____

Are there any current dental problems?.....YES NO

Is your child experiencing any dental pain?.....YES NO

Are you happy with the straightness of your child's teeth?.....YES NO

Do you feel your child needs braces?.....YES NO

What can we do to make this visit better for you and your child? _____

I authorize release of any information relating to all dental claims.



Signed (Patient Or Parent If Minor)

Date

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.



Signed (Patient Or Parent If Minor)

Date