

Barry D. Lyon, D.D.S. & Associates, L.L.C.
Child's Registration, Health History, and Informed Consent

Child's Full Name _____ SS# _____ Age ____ Birthdate _____
 Address/City/Zip _____ Phone _____
 Father's Name _____ Address _____
 Phone _____ Birthdate _____ Social Security Number _____
 Occupation _____ Employer _____ Work Phone _____
 Name of Father's Dental Insurance _____
 Mother's Name _____ Address _____
 Phone _____ Birthdate _____ Social Security Number _____
 Occupation _____ Employer _____ Work Phone _____
 Name of Mother's Dental Insurance _____
 Person(s) Financially Responsible _____
 Has Your Child Been Seen In This Office Before? _____ When? _____
 Are There Brothers/Sisters Being Treated Here? _____ Who? _____
 Names/Ages of Brothers/Sisters _____
 How Did You Hear Of Our Office? _____

Name Of Your Child's Physician? _____
 Is Your Child Under A Doctor's Care? Yes No Reason _____
 Is Your Child Taking Any Medications Yes No Name of Medication _____
 Has Your Child Ever Been Hospitalized? Yes No Reason _____
 Has There Ever Been A Blood Transfusion? Yes No Reason _____
 Are There Allergies To Foods Or Medicines? Yes No Name _____
 Circle If Your Child Has/Had Any Of The Following: ADHD AIDS ARC Asthma Cancer
 Diabetes Emotional Problems Epilepsy Food Allergies Heart Disease/Murmur/Surgery
 Hepatitis HIV+ Kidney/Liver Disease Mental Retardation Rheumatic Fever Surgery
 Tested For AIDS Other Not Listed _____

Has Your Child Been To The Dentist Before? _____ If So, Who? _____
 When _____ Reason _____ Were X-Rays Taken? _____
 Is Your Child Currently Experiencing Dental Pain? _____ Reason _____
 Have There Been Any Injuries To The Mouth? _____ When? _____
 Does Your Child Have Any Habits? (Circle) Bottle Thumb/Finger Sucking Pacifier
 Does Your Child Brush/Floss Daily? _____ Do You Assist? _____ Is Your Water From A Well? _____
 Are You Happy With The Straightness Of Your Child's Teeth? _____
 Do You Feel Your Child Needs Braces? _____

Please Continue On The Other Side...

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

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

X

X

Signed (Patient Or Parent If Minor)

Date

Signed (Patient Or Parent If Minor)

Date

Do you have any concerns or questions regarding your child's dental health, dental care, or dental visits? _____

I have been informed of the need for my child to undergo dental treatment. And, I have been fully informed about the details of the recommended treatment and alternatives and I agree to accept the treatment.

I understand that as treatment proceeds, there may be the need to change the treatment plan.

I further understand that individual reactions during or following treatment cannot be predicted, and if my child experiences any unanticipated reactions during or following treatment, I agree to report them to the office as soon as possible.

I have been told that the success of the recommended treatment depends upon my cooperation in keeping the scheduled appointments, following home care instructions, including oral hygiene and dietary instruction, and reporting to the office any changes in my child's health status as soon as possible.

I have discussed all of the above with the doctor, and all of my questions have been answered. I further acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I understand that there may be side effects from dental treatment that may include, but not be limited to the following: infection, pain, swelling, laceration of oral tissues, aspiration or swallowing of objects, and emotional upset.

[For those patients having nitrous-oxide used] I understand that nitrous-oxide (Laughing Gas) is going to be used with my child. I have been informed that my child will be fully awake, able to speak, understand, and answer questions. Further, I have been informed that it is used to make my child more comfortable and to help allay any fears or anxieties that he/she may have. I understand that my child should not eat or drink for five hours prior to the appointment when nitrous-oxide is being used. The doctor has told me that the complications, if they occur, can include nausea, vomiting, and drowsiness. I consent to allow the use of nitrous-oxide.

Following the explanation, the discussion, and the answers to my questions, I authorize the treatment to be completed and agree to pay the charges I incur.

Child's Name _____ Signature of Parent _____ Date _____

For Doctor's Use Only

I affirm that I have read the above health history, explained the proposed treatment and the inherent risks of said treatment to the patient's parent(s) or responsible guardian(s).

Signature of Dentist _____ Date _____