



CAROL LYBROOK, D.D.S. | SCOTT LYBROOK, D.M.D.

*Welcome and thank you for choosing us to provide your dental care. We are a family oriented practice, offering a wide range of services for both children and adults. We want to help you achieve optimal dental health; comfort, function and appearance. We work in a friendly atmosphere that allows you to feel at home and relaxed.*

*Whether you are new to the area or new to our office, we would like to get to know you. Since your dental care can be affected by other health problems or allergies, we ask you to complete a health questionnaire and patient forms as completely and accurately as possible.*

*All visits are by appointment. This ensures that we are able to spend enough time with each patient to get the best possible results. If you have an emergency, please call before your arrival so we can prepare for you. If you need to reschedule, please give at least 48 hours notice so we can then accommodate another patient.*

*We appreciate you as a patient in our practice and we welcome any questions or concerns you may have about our services or office protocol.*

*And, if you are comfortable in our office, please suggest us to a friend. A referral from you is one of the nicest compliments we could receive.*

*Sincerely,*

*Carol Lybrook, D.D.S.*

*Scott Lybrook, D.M.D.*



# LYBROOK DENTAL

Innovative Comprehensive Dentistry

**551 Kokopelli Blvd. · Kokopelli Professional Plaza**  
**Fruita, CO 81521 · 970-858-9511**  
[www.lybrookdental.com](http://www.lybrookdental.com)

## WELCOME

Date: \_\_\_\_\_  
Legal Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
I prefer to be called \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_  
Birth date: \_\_\_\_\_ Age: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Social Security# \_\_\_\_\_  
Driver's License# \_\_\_\_\_  
e-mail: \_\_\_\_\_  
May we confirm your appointments using your e-mail address? Yes \_\_\_\_\_ No \_\_\_\_\_  
Employer: \_\_\_\_\_ How long at job \_\_\_\_\_  
Address: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### Parent or Spouse Information

His/Her Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Soc. Sec. #: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Employer: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Drivers License #: \_\_\_\_\_

### Dental History

Previous/Present Dentist: \_\_\_\_\_ Last Visit Date \_\_\_\_\_

Why have you come to the dentist today? \_\_\_\_\_  
\_\_\_\_\_

Are you currently in pain? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had a serious/difficult problem associated with any previous dental work?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Do you or have you ever-experienced pain/discomfort in your jaw joint (TMJ, TMD)?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Your current Dental Health is: Good \_\_\_ Fair \_\_\_ Poor \_\_\_

Do you like your smile? Yes \_\_\_\_\_ No \_\_\_\_\_

Do your gums ever bleed? Yes \_\_\_ No \_\_\_ How many times a week do you floss: \_\_\_\_\_  
How many times a day do you brush? \_\_\_\_\_ Type of bristles? Hard \_\_\_ Medium \_\_\_ Soft \_\_\_

**Medical History**

Do you have a personal Physician? Yes\_\_\_ No\_\_\_ Physician's Name: \_\_\_\_\_

Phone# \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

In case of emergency, whom should we contact?

His/Her Name? \_\_\_\_\_ Relationship: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Your current physical health is: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Are you currently under the care of a physician? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you taking any prescription/over the counter drugs? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list each one: \_\_\_\_\_

\_\_\_\_\_

**For Women only:**

Are you taking birth control pills? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Week #: \_\_\_\_\_

Are you nursing? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list any medical condition(s) you now have or have ever had: \_\_\_\_\_

\_\_\_\_\_

**Are you allergic to any of the following:**

Aspirin \_\_\_ Erythromycin \_\_\_ Codeine \_\_\_ Latex Gloves \_\_\_ Penicillin \_\_\_

Jewelry/Metal \_\_\_ Dental Anesthetics \_\_\_ Tetracycline \_\_\_ Other (explain) \_\_\_\_\_

Please list any drugs you are allergic to: \_\_\_\_\_

\_\_\_\_\_

**Please CIRCLE all of the medical problems you currently have or have ever had:**

- |                       |                      |                             |                    |
|-----------------------|----------------------|-----------------------------|--------------------|
| Artificial Joints     | Abnormal Bleeding    | Fever Blisters/Herpes       | Shingles           |
| Blood Transfusions    | Anemia               | Glaucoma                    | Sinus Problems     |
| Cong. Heart Defect    | Asthma               | Heart Attack                | Stroke             |
| Heart Murmur          | Arthritis            | Heart Trouble               | Ulcers             |
| Heart Pacemaker       | Cancer               | Hemophilia                  | Venereal Disease   |
| Mitral Valve Prolapse | Chemotherapy         | High/Low Blood Pressure     | Diabetes           |
| Rheumatic Fever       | Colitis              | Hospitalized for any reason | Gluten Intolerance |
| Heart Surgery         | Difficulty Breathing | Kidney Problems             | Osteoporosis       |
| Hepatitis             | Drug/Alcohol Abuse   | Psychiatric Problems        | Thyroid            |
| HIV/AIDS              | Emphysema            | Radiation Treatment         | Acid Reflux        |
| Tuberculosis (TB)     | Epilepsy             | Severe/Frequent Headaches   |                    |

*I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I any need during diagnosis and treatment with my informed consent.*

SIGNATURE: \_\_\_\_\_

Date

**\*PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**

**Doctor's Comments:**

I verbally reviewed the medical/dental information above with the patient named herein.

Date	Comments	Signature
_____	_____	_____
_____	_____	_____

# Financial Policy

We strongly feel that all patients deserve from us the finest dental care that we can provide. You will benefit from the high standards we have set for delivering the utmost quality of dental treatment available. We also feel that when financial arrangements are discussed and agreed upon, everyone benefits. Accordingly, we have prepared this information to acquaint you with our financial policy.

***PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGMENTS HAVE BEEN MADE.***

Please indicate below the method of payment that you will use to pay for the dental treatment.

## Payment Options:

\_\_\_\_\_Cash or Check

\_\_\_\_\_Visa/Master Card/American Express/Discover

## Extended Payment Options:

\_\_\_\_\_Capital One Healthcare Finance – Credit Application Required

## Dental Insurance

Our office will do everything possible to help you understand and make the most of your dental insurance. We do accept insurance benefits as partial payment for treatment along with your payment of the estimated patient portion cost. You are responsible for all fees and charges for your account. Please be assured our staff will do all that we can do to help you receive maximum reimbursement from your insurance company.

## Insurance Information:

Primary Insurance Carrier: \_\_\_\_\_

Group Number: \_\_\_\_\_

ID Number: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

## Missed Appointment Policy

Unforeseen events sometimes require missing an appointment. If you need to cancel or reschedule an appointment, we respectfully request notification of at least **24 hours in advance** to avoid a charge. If you fail to arrive for your appointment and have not notified us **24 hours in advance**, your account may be assessed a Missed Appointment Fee of \$50.00.

Thank you for choosing us to meet your dental goals. Our commitment to quality is equal only by our commitment to exceptional customer service. Our staff is here to assist you in anyway we can. Please let us know if you have any questions or concerns.

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I have read the Lybrook Dental Center Financial Policy and I understand and agree to this policy.

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Signature of Patient or Responsible Party Date

## GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. Drug or chemical reaction. Dental materials and medications may trigger
2. allergic or sensitivity reactions.
3. Long-term numbness (paresthesia). Local anesthetic, or its administration,
4. while almost always adequate to allow comfortable care, can result in
5. transient, or in rare instances, permanent numbness.
6. Muscle or joint tenderness. Holding one's mouth open can result in
7. muscle or Jaw joint tenderness, or in a predisposed patient, precipitate a
8. TMJ disorder.
9. Sensitivity in teeth or gums, infection or bleeding.
10. Swallowing or inhaling small objects.

While we follow procedural guidelines that most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page:

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Signature (if minor patient)

\_\_\_\_\_  
Date



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