

Patient Information

Patient Name: _____ Date: _____
Last First MI
Preferred name: _____ Male Female / Married Single Child Other _____
Birth Date: _____ Social Security: _____
Phone (Primary): _____ (Work): _____ Ext: _____ Best time to call: _____
Phone (Home): _____ (Cell): _____ Email address: _____
Address: _____
Street Apartment #/ Unit #
City State Zip Code

Health Information

Date of Last Dental Visit: _____	Reason for this visit: _____
Bad breath _____ Yes ___ No	Jaw pain or tiredness _____ Yes ___ No
Bleeding gums _____ Yes ___ No	Lip or cheek biting _____ Yes ___ No
Blisters on lips or mouth _____ Yes ___ No	Loose teeth or broken fillings _____ Yes ___ No
Burning sensation on tongue _____ Yes ___ No	Mouth breathing _____ Yes ___ No
Chew on one side of mouth _____ Yes ___ No	Orthodontic treatment _____ Yes ___ No
Cigarette, pipe or cigar smoking _____ Yes ___ No	Pain around ear _____ Yes ___ No
Clicking or popping jaw _____ Yes ___ No	Periodontal treatment _____ Yes ___ No
Dry mouth _____ Yes ___ No	Sensitivity to cold _____ Yes ___ No
Food collection between teeth _____ Yes ___ No	Sensitivity to heat _____ Yes ___ No
Grinding teeth _____ Yes ___ No	Sensitivity to sweets _____ Yes ___ No
Gums swollen or tender _____ Yes ___ No	Sensitivity when biting _____ Yes ___ No
How often do you brush? _____	Sores or growths in your mouth _____ Yes ___ No
How often do you floss? _____	Name of previous dentist _____

Have you ever had or currently have any of the following? Please check those that apply:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Sulfa Allergy
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Growths	<input type="checkbox"/> Mitral Valve Prolaps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Tumors
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Penicillin Allergy	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pregnant Now	Other/ Drug allergies:
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hepatitis A B C	Due date: _____	<input type="checkbox"/> _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> _____
<input type="checkbox"/> Codeine Allergy	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> _____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Rheumatism	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Problems	
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Stomach Problems	
<input type="checkbox"/> Fainting	Allergy/ EPI	<input type="checkbox"/> Stroke	

• List any medications you are taking: _____

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No • Name of Physician: _____ Phone: _____
If yes, please explain: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

• In case of emergency – contact name and phone number _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____ **(OVER)**
Rev 06/07

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #/ Unit #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Name of Insured: _____ is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____ SSN# _____

Insurance Plan Name and Address: _____

Consent for Services/ Use of Information

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition. If collection proceedings are instituted, I further agree to be responsible for the payment of all costs of collection, including, but not limited to court costs, reasonable attorney's fees and expenses.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I agree to allow Lykins Family Dentistry to use photographs of any portion of my dental treatment for the purpose of teaching, in dental & health publications, and any marketing or advertising medium.

We require a 24 hour cancellation notice to be able to better assist our patients and we reserve the right to charge a \$50 cancellation fee.

I have read the above conditions of treatment and payment and agree to their content.

Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Lykins Family Dentistry 60 Highland Ct, Suite 202 East Ellijay, GA 30540 706-698-3384

Referrals:

Who can we thank for referring you to Lykins Family Dentistry? _____ Rev 09/07

LYKINS FAMILY DENTISTRY
Shay D. Lykins, DMD
60 Highlands Court Suite 202
East Ellijay, GA 30540

Financial Policy and Basic Insurance Information

We have prepared this especially for our patients so they will have a definite and clear understanding of our financial policy prior to their treatment.

Patients with insurance: As a courtesy, our office will file insurance but we must have ***current and correct information provided.*** You will be expected to pay your deductible and co-payment at the time of service. If your insurance company denies or makes less than full payment, you are responsible for the entire balance at that time. In the event an insurance payment produces a credit balance, we will refund you promptly. ***We do not file secondary insurance.***

It is your responsibility to monitor your benefits and annual maximum.

Patients without insurance: You will be expected to pay at the time of service unless other arrangements have been made prior to your appointment.

Please note: There will be a broken appointment charge of \$50.00 for any patient who repeatedly (***more than once***) cancels with less than 24 hour notice or who fails to keep an appointment,

For your convenience, we accept cash, personal checks (no counter/starter checks), American Express, Visa, MasterCard, and Discover. We also offer third party financing thru CitiHealth™ card for those parties who are in need of more extensive treatment.

We welcome you to our office with a promise of excellent dental care and a friendly, caring staff.

Patient Signature

Date

Lykins Family Dentistry
60 Highland Ct., Suite 202
East Ellijay, GA 30540
706-698-3384

HIPPA Consent for use and disclosure of Health Information

Section A: Patient giving consent

Name: _____

Address: _____

Telephone: _____

DOB: _____ Social Security#: _____

Section B: To the patient. Please read

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully before signing.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain changes.

You may obtain a copy of our Notice of Privacy Practices at any time by contacting:

Contact Person: Teresa Hughes or Sandy Bielefeldt
Telephone: 706-698-3384

Signature:

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date _____

If this consent is signed by personal representative on behalf of patient, complete the following:

Personal Rep Name: _____

Relationship to Patient: _____

Revocation of Consent

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature_____ Date_____



Shay D. Lykins D.M.D.
Office Policy For Patient Appointments

1. We require a 24 hour notice for cancellation of a patient appointment.
2. For appointments that are not cancelled or kept there will be a \$50.00 charge. This charge is payable **before** you can schedule another appointment. This charge is not reimbursed by your insurance company.
3. After three (3) No Call/No show appointments you will be discharged from our practice.

We sincerely hope that this policy will enable us to better serve you in the future. When patients do not call or show up for their appointment time it decreases the availability of appointments we have for other patients. Please help us help you by providing our office staff with all phone numbers that we may use to remind you of your appointment times. If you have any questions please do not hesitate to ask them.

Home () _____

Work () _____ May we contact you here? Yes No

Cell () _____ Do you accept text messaging? Yes No

I understand and agree with the policy.

Patient

Date