Please fax back to Lykins Family Dentistry @ 706-698-3383. Please use this number *only* to fax these forms.
Completely filling out each section and getting it to us before your appointment helps in our attempts to run on schedule.

Patient Information

Patient Name: _____ Date:_____
Last First MI

Preferred name: _____ ☐ Male ☐ Female / ☐ Married ☐ Single ☐ Child ☐ Other_____

Birth Date: _____ Social Security:_____

Phone (Primary): _____ (secondary): _____ (third) _____email:_____

Address: _____
Street Apartment #/ Unit #

_____
City State Zip Code

Health Information

(Information in bold may be obtained from your previous dentist or insurance company, and is ***REQUIRED*** on your 1st visit)

Name and phone # of previous dentist_____ Date of Last Dental Visit: _____
Date of last cleaning_____ Date of last x-ray_____ Type of last x-ray_____
How often do you brush? _____ How often do you floss? _____

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
		Sores or growths in your mouth	__ Yes __ No

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

- ☐ AIDS
- ☐ Angina Pectoris
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer_____
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Local Anesthetic/ Allergy-Epinephrine
- ☐ Mineral Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Pregnant Now Due Date_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Other/ Drug allergies:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

- List any medications you are taking: _____
- Have you ever or are you currently taking Bisphosphonates or Fen-Phen _____
- 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.

*

_____ Date:_____

(***OVER***)

Signature of patient or parent/ guardian, if patient is under 18 years of age

Spouse or Responsible Party Information

This portion ***must*** be filled in. The following is the person that is being requested to be responsible for payment of this patient bill. If there is a discrepancy, regardless of who is entered here, the person signing these forms will be held responsible for payment of services.

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date: _____ Social Security: _____

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

This part must be filled out completely. In addition, please send an enlarged copy, front & back, of your card.

Name of Subscriber: _____ 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 or parent/ guardian, if patient is under 18 years of age

* _____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party, must be 18 years of age

Lykins Family Dentistry 78 River Terrace Ellijay, GA 30540 706-698-3384

Please tell us how you heard about Lykins Family Dentistry? _____ Rev 07/08

LYKINS FAMILY DENTISTRY
Shay D. Lykins, DMD
78 River Terrace
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 Care Credit™ 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
78 River Terrace
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 us at 706-698-3384

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: _____

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 (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

78 River Terrace *East Ellijay, GA 30540 *(706) 698-3384 *Fax (706) 698-3383