

Bryn Gardd Dental Care  
Thomas B. Lyke, D.D.S and John D. Gillard D.D.S.

## ACQUAINTANCE FORM

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Driver's License \_\_\_\_\_  
SS# \_\_\_\_\_ Email Address \_\_\_\_\_  
Employer \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_  
Person responsible for statement \_\_\_\_\_ Home phone \_\_\_\_\_  
Address (if different from above) \_\_\_\_\_  
Referred by \_\_\_\_\_  
Closest Relative not living with you \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

Do you have double coverage?  
Yes \_\_\_\_\_ No \_\_\_\_\_

#### Your Dental Insurance Company

Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone# \_\_\_\_\_  
Badge# \_\_\_\_\_ Group# \_\_\_\_\_  
Union & Local# \_\_\_\_\_  
Social Security# \_\_\_\_\_  
Date of Birth \_\_\_\_\_

#### Spouse's Dental Insurance Company

Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone# \_\_\_\_\_  
Badge# \_\_\_\_\_ Group# \_\_\_\_\_  
Union & Local# \_\_\_\_\_  
Social Security# \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**HEALTH HISTORY: Patient's Name:** \_\_\_\_\_

**If your list of medications or allergies is large please attach a copy to the health history form.**

Name and Phone Number of your MEDICAL Doctor or Clinic

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Do you have any allergies, if so please list them? (Sulfa Drugs, Sedatives, Iodine, Aspirin, Antibiotics, Etc.) \_\_\_\_\_

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Please list all medications, supplements and over the counter medications you are presently taking \_\_\_\_\_

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Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?

Yes \_\_\_\_\_ NO \_\_\_\_\_

**Indicate which of the following you have had or have at present. Check all that apply.**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Pre-Med-Clind      | <input type="checkbox"/> Pre-Med-Other        | <input type="checkbox"/> Pre-Med-Amox           | <input type="checkbox"/> Abnormal Bleeding    |
| <input type="checkbox"/> Allergy-Aspirin    | <input type="checkbox"/> Allergy-Codeine      | <input type="checkbox"/> Allergy-Latex          | <input type="checkbox"/> Allergy-Other        |
| <input type="checkbox"/> Allergy-Penicillin | <input type="checkbox"/> Allergy-Sulfa        | <input type="checkbox"/> Allergy Dental Anest   | <input type="checkbox"/> Allergy-Erythromycin |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joints    |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Bisphosphonates      | <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Blood Thinner        |
| <input type="checkbox"/> Blood Transfusion  | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Chemo/Radiation        | <input type="checkbox"/> Cholesterol          |
| <input type="checkbox"/> Colitis            | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Drug Abuse             | <input type="checkbox"/> Emphysema            |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Excessive bleeding   | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Head Injuries        |
| <input type="checkbox"/> Heart Attack       | <input type="checkbox"/> Heart Defects        | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Heart Murmur         |
| <input type="checkbox"/> Heart Surgery      | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Hepatitis A, B, or C   | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Liver Disease        |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Nervous Disorders      | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Other              | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Persistent Cough       | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Sinus Problems         | <input type="checkbox"/> Stomach Problems     |
| <input type="checkbox"/> Transplant         | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Tumors                 | <input type="checkbox"/> Ulcers               |

Are you under a doctor's care for any other medical conditions not listed above? Have you been a patient in the hospital in the past year?

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**FOR FEMALES ONLY**

**Are you pregnant? If yes, when is your due date?**

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**ASSIGNMENT AND RELEASE**

Patients Name: \_\_\_\_\_

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign to BRYN GARDD DENTAL all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Signature of patient, parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR SERVICES**

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 acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

As a condition of treatment by this office, financial arrangement must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 unless other arrangements are made.

A service of 18% annual on the unpaid balance will be charged on all accounts exceeding 90 days.

I understand that any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for service shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

Signature of patient, parent or guardian (responsible party):

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT**

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 operation, of the uses and disclosure 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 and completely before signing this Consent.

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting any of our staff members.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information.

Patients Name \_\_\_\_\_

We reserve the right change our privacy practice 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 the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of privacy Practices, including any revisions of our Notice, at any time by contacting:

Thomas B. Lyke D.D.S.  
320-587-2769  
Address P.O. Box 217 Hutchinson, MN. 55350

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the Consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

I, \_\_\_\_\_ have had full opportunity to read and consider the contents of the Consent form and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent from, 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 \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**FILL OUT BELOW "ONLY" IF YOU ARE REVOKING THIS CONSENT**

**Revocation of Consent**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care 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 Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_