Dr. Yury Geylikman PC
TMJ Disorders and Injury; Neuromuscular dentistry
Dento-Facial Orthopedics and Orthodontics

Patient referral sheet

Confidential

Referral Date

First Name: _____ Last Name: _____
Sex: _____Date of Birth: _____ SS: _____
Occupation: _____Address:
City, State, Zip: Phone No: _____
CLAIM #W: _____WCAB#:_____
Date of Injury: _____ __Date of Exam: _____

Claims Administrator/Insurer
Name: _____Address:_____
City, State, Zip: Phone: _____
Claims Examiner: _____
Employer Name: _____Address:_____
City, State, Zip: _____Phone: _____

Attorney name **Contact**

Attorney Address

Referring Party's Name:
Contact:

Diagnostic or suspected condition:

Services Requested:

[ ] Consultation only

[ ] Consultation and Treatment

Signature **Date**

12626 Riverside Drive, Suite 408, Valley Village CA 91607
(323) 656-9111; fax (323) 650-9669; office@dryury.com

NEW PATIENT REFERRAL QUESTIONNAIRE

*Chief Complaint:*_____

Liability cleared *[ ] yes[ ] no*

Policy limit: (if none)

Police Report *[ ] yes[ ] no*

TMJ treated some wear else? *[ ] yes[ ] no*

*Treatment tried so far:*_____

How soon does patient need to be seen?

Emergency (ASAP or 1 week)

Urgent (2 weeks)

**PATIENTS WILL NOT BE SCHEDULED UNTIL COMPLETED FORM*

AND RELEVANT REPORTS ARE RECEIVED

12626 Riverside Drive, Suite 408, Valley Village CA 91607
(323) 656-9111; fax (323) 650-9669; office@dryury.com

NOTICE OF DOCTOR'S LIEN

To: Attorney

From: Dr. Yury Geylikman PC

RE: Medical/Dental Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for medical service rendered me by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all procedures of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. If this is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees, and/or court costs will be added to the total amount due.

Patient's Name (print):

Date of Accident: _____Patient's Signature:

Today's Date: _____Patient's Address:

Acknowledgement of Attorney

The undersigned being attorney of record for the above patient does not hereby agree to observe all the terms of the above to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor named above.

ARBITRATION CLAUSE: Any dispute out of or related to professional services rendered by Dental Injury Center and/or Yury B. Geylikman, A Professional Dental Corporation and/or Dr. Yury Geylikman, including but not limited to any and all issues concerning this lien should be resolved by Arbitration and through an Arbitrator chosen from the ADR Services Inc. panel located at 1900 Avenue of the Stars, Suite 250, Los Angeles, California 90067. The cost of said Arbitration should be borne by the Attorney and the Client(s). Attorney and Client(s) are waiving their rights to have a jury trial concerning these issues. The Arbitration process will be governed by the California Code of Civil Procedure.

Dated: _____ Attorney's Signature: _____

This office holds an assignment/lien on this case for services rendered. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. (UNDER CALIFORNIA STATE INSURANCE CODE #10133)

Attorney: Please date, sign and return one copy to above doctor's office at once. Keep one copy for your records.

12626 Riverside Drive, Suite 408, Valley Village CA 91607
(323) 656-9111; fax (323) 650-9669; office@dryury.com

12626 Riverside Drive, Suite 408, Valley Village CA 91607
(323) 656-9111; fax (323) 650-9669; office@dryury.com