CYE S. JEKEL, DDS
Family & Cosmetic Dentistry

New Patient Packet

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Special Note to New Patients:

A professional cleaning performed by a dental hygienist or a dentist is a medical procedure and must be prescribed by a qualified health care practitioner. In some cases, dental conditions exist that have to be addressed before a cleaning is possible. Other types of treatment may be necessary first to best provide for the health of the patient.

Legally and ethically, an examination and x-rays, as required by the dentist, must be done before any treatment can began. After an exam has been completed and x-rays have been evaluated, Dr. Jekel will be able to determine the order of treatment procedures.

Dr. Jekel and his team are committed to helping our patients achieve and maintain healthy teeth and gums for a lifetime. Our goal is to provide you with optimum oral and overall health.

I have read and understand the above statement, I have been given the opportunity to clarify and ask questions regarding my treatment.

Signature: Date:

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OFFICE POLICIES

Dear Patient,

Welcome to the practice of Cye S. Jekel, D.D.S. We appreciate your selection of our office to serve your dental needs. Our goal is to provide the highest quality of dental care to you and be a resource in your overall health. Please be aware of our office policies.

HOURS AND APPOINTMENTS

The office is open Monday thru Thursday from 8:00 A.M. to 5:00 P.M.
Your appointment time is reserved specifically for you. If you are unable to keep an appointment, please provide us with 24 hour notice.

FAILURE TO PROVIDE 24 HOUR NOTICE OF CANCELLATION WILL RESULT IN A BROKEN APPOINTMENT FEE OF $100.00 PER APPOINTED HOUR.

PAYMENT

Payment is due at the time services are rendered. We accept cash, personal check, and major credit cards.

There is a $35.00 fee payable to Cye. S. Jekel D.D.S. for a returned check from your bank.

INSURANCE

Insurance coverage and benefits are between the patient and the insurance company. Our office will file all insurance claims electronically for you to allow for the insurance company to reimburse you in the most efficient manner possible.

Signature: Date:

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Consent for Internet Communications

Patient Name:

Email Address:

I grant my permission to Cye S. Jekel, D.D.S. to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured website for the office of Cye S. Jekel, D.D.S. I understand that for security purposes the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Cye S. Jekel, D.D.S. is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or to access and use the dental practice website with my ID and password. I also agree to immediately notify Cye S. Jekel, D.D.S. of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that state and federal laws, as well as ethical and licensure requirements, impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the office of Cye S. Jekel, D.D.S. will represent and warrant that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the office of Cye S. Jekel, D.D.S. has the right to monitor, retrieve, store, upload, and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the office of Cye S. Jekel, D.D.S. will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the office of Cye S. Jekel, D.D.S. CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITERED, SORTED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the website for Cye S. Jekel, D.D.S. and authorize permission to securely upload my patient information to the website.

Signature:

Date:

Relationship to Patient:

Cye S. Jekel, DDS
Family & Cosmetic Dentistry

Patient Name:

First | Last | Preferred Name

Gender:
- ◯ Male
- ◯ Female

Family Status:
- ◯ Married
- ◯ Single
- ◯ Child
- ◯ Other

Birth Date:

Social Security #:

E-mail Address:

Phone: Cell | Work | Home | Other

Address: Street

City | State | Zip Code

Who may we thank for referring you?

Place of Employment/Position

Other family members seen by us?

Previous Dentist and reason for switching?

Suggestions on how we could accommodate you better?

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MEDICAL HISTORY

Do you have, or have had any of the following?

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Bisphosphonates
- ☐ Breathing Problems
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Pacemaker
- ☐ Liver Disease
- ☐ Radiation Treatment
- ☐ Stomach Problems
- ☐ Thyroid Problems
- ☐ Allergies/Sinus
- ☐ Artificial Heart Valve
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Epilepsy
- ☐ Hay Fever
- ☐ Hepatitis A/B/C
- ☐ Mental Disorders
- ☐ Rheumatism
- ☐ Stroke
- ☐ Ulcers
- ☐ Alzheimer's Disease
- ☐ Artificial Joint
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Respiratory Problems
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Venereal Disease
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Chemotherapy
- ☐ Fainting/Dizziness
- ☐ Heart Murmur
- ☐ Kidney Problems
- ☐ Nervous Disorders
- ☐ Rheumatic Fever

Do you have other medical conditions or any drug allergies?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Epinephrine
- ☐ Latex
- ☐ Codeine
- ☐ Dental Anesthetic
- ☐ Sulfa
- ☐ Metal

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MEDICAL HISTORY CONTINUED

Please list any medications you are taking (prescription and over-the-counter) or have recently been taking:

Do you, or have you EVER taken Fosamax, Boniva, Actonel, Osteoporosis medication or any other bone density medications?

Do you take antibiotics prior to dental procedures?

- ◯ Yes
- ◯ No

Women:

Are you currently pregnant?

- ◯ Yes
- ◯ No

Are you on birth control?

- ◯ Yes
- ◯ No

Are you nursing?

- ◯ Yes
- ◯ No

DENTAL HISTORY

Do you have any of the following?

- ☐ Dental pain
- ☐ Jaw pain
- ☐ Bleeding gums
- ☐ Loose/broken teeth
- ☐ Hot/cold sensitivity
- ☐ Biting discomfort
- ☐ Lost fillings
- ☐ Clenching/grinding

How frequently do you brush?

How frequently do you floss?

Reason for your dental visit today?

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Authorization

I hereby certify that I have read and understand the information in the new patient packet. I certify that all the information submitted by me on the health history form is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health as Dr. Jekel may be unable to effectively treat me if I provide false information.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, and/or other diagnostic aids deemed appropriate.

I authorize Dr. Jekel and his staff to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to be submitted directly to Dr. Jekel if there is a outstanding balance on my account.

I understand that insurance coverage and benefits are between me and the insurance company. Our staff will provide assistance with filing insurance claims properly and completely to ensure that I am reimbursed to the limits of my coverage. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature

Date

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Notice of Privacy Practices

Patient's Acknowledgement of Receipt

I hereby acknowledge that I have read a copy of the Notice of Privacy Practices of Cye S. Jekel, D.D.S. I further acknowledge that a copy of the current notice will be posted in the reception area and at www.cyejekeldds.com I may also have a copy upon request.

Printed Name

Signature

Date

If not signed by the patient, please indicate relationship:

- ◯ Parent or guardian of minor patient
- ◯ Guardian or conservator of an incompetent patient
- ◯ Beneficiary of personal representative of deceased patient

Name of Patient:

The following individuals are permitted access to my private health information including exam results, treatment planning, treatment rendered, pending treatment and account balance upon request.

List the names of any persons to whom you are allowing access to your healthcare information.