CYE S. JEKEL, DDS
Family & Cosmetic Dentistry

Welcome!

Welcome to the practice of Cye S. Jekel, D.D.S. We appreciate the trust you place in our team to serve your dental needs. Our goal is to provide the highest quality dental care for you and to be a resource in your overall health. We strive to create a warm and inviting atmosphere.

A professional cleaning and exam performed by a dentist or dental hygienist is a medical procedure and must be prescribed by a qualified healthcare practitioner. Dental conditions may exist that must be addressed before a cleaning is feasible. Other treatment may be necessary first to best provide for the health of the patient.

Legally and ethically an examination and annual x-rays must be obtained before treatment can begin. Once an exam has been performed and x-rays evaluated, Dr. Jekel will determine the order of treatment.

Dr. Jekel and his team are committed to assisting our patients achieve and maintain healthy teeth and gums for a lifetime.

Our office is open Monday through Thursday from 8 am to 5pm. Your appointment time is reserved specifically for you. If you are unable to keep an appointment, please provide a 24 hour notice. ***Failure to provide 24 hour notice of cancellation will result in a broken appointment fee of $100 per appointed hour.***

Payment

Payment is due at the time services are rendered. We accept cash, check and major credit cards. A $35.00 will be assessed by our office for a returned check.

Insurance

Insurance coverage and benefits are between the patient and the insurance company. Our office will submit all insurance claims electronically to provide expeditious reimbursement. If a procedure(s) is not covered or downgraded, the uncovered amount will be the responsibility of the patient.

I understand that while Dr. Jekel's office will submit electronically to my insurance company, I am financially responsible for my dental treatment.

_____

Signature

Date _____

Communication

I authorize the office of Cye S. Jekel to communicate with me via electronic means (email and text) for appointment reminders and general information.

_____

Signature

Date _____

Authorization

I hereby certify that I have read and understand the office policies of the practice of Cye S. Jekel, D.D.S. 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 payment from my insurance carrier to be submitted to Dr. Jekel if there is an outstanding balance on my account.

I understand that insurance coverage and benefits are between the subscriber in my household and the insurance company. The filing of claims by Dr. Jekel's staff is a provided service but I understand that I agree and consent that I am financially responsible for payment of services on my behalf or of my dependents.

_____

Signature

Date _____

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Medical and Dental History

Patient Name: First _____ Last _____ Preferred _____

Gender: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child DOB _____

SS# _____ Email address _____

Phone: Cell _____ Work _____ Home _____

Address: _____

Street number & name City State Zip Code

Who may we thank for referring you? _____

Place of Employment/Position _____

Other family members seen by our dental office _____

Previous dentist _____ Approx. Last dental visit _____

Reason for changing providers _____

How might we serve your needs better? _____

Medical History

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

Allergies

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

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Medications you are currently or have recently been taking (prescription & over-the-counter):

Do you or have you *ever* taken medications for bone density? ☐ When?

Do you take antibiotics prior to dental procedures? ☐ Yes ☐ No

Female Patients:

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Birth Control ☐ Yes ☐ No

Are you experiencing any of the following?

Dental Pain ☐ Loose/broken teeth ☐ Lost fillings ☐ Jaw Pain ☐ Hot/cold sensitivity ☐

Clenching/grinding ☐ Bleeding gums ☐ Bleeding gums ☐ Biting Discomfort ☐

How frequently do you brush? How frequently do you floss?

Reason for your dental visit today?

I certify that the above information regarding my medical and dental health is complete and accurate

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 receive a copy upon request.

Printed Name _____ Signature _____

If not signed by patient, please indicate your relationship to the patient and printed name: _____

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an impaired patient

☐ Beneficiary or personal representative of deceased patient

Name of Patient _____ Signature of Patient Representative _____

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

Please print the names of any persons to whom you are allowing access to your healthcare information:

_____ _____

_____ _____