KYGER
Dental Associates

878 Jackson Pike, Gallipolis, OH 45631
Call/text: 740- 446-7806
Fax: 740-446-4840
deanna@kygerdental.com

Our dental team is happy to welcome you to our practice. Because your dental health is our top priority, we strive to provide you with the highest quality dental care.

Here is a list of things to take care of **BEFORE** your upcoming appointment:

- Please read and complete the following paperwork.
- If you have a pre-existing medical condition such as prosthetic heart valves, previous endocarditis, congenital heart disease, or artificial joints, please call and inform us prior to your appointment.
- If you are on multiple medications, please bring a complete list with you to your appointment
- If you have dental insurance and did not already give us that information, please call us before your appointment so we can make sure there aren't any problems.
- If you have had dental x-rays taken at any other office in the last five years, please get those and bring them to your appointment or you will have to pay out of pocket for new ones.
- If you do not have current x-rays, we will take bitewing and panoramic x-rays or a full mouth series at your initial appointment.

At this appointment, you can expect a comprehensive exam including necessary x-rays, careful evaluation of your dental status, and a discussion of the most appropriate treatment plan to meet your oral health goals. We will listen carefully to your dental concerns and answer your questions thoroughly.

We have reserved time especially for you. We request at least 24 hours notice if you need to change an appointment.

If you have any questions, please feel free to call, text, or email. We look forward to seeing you!

Cordially,

Deanna Watts
Business Manager

Patient Information

Patient Name: _____ Date: *10/10/2019*
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Gender: _____ Family Status: _____

Home Phone: _____ Cell Phone: _____ Work: _____ Ext: _____

E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of last dental visit: _____ Reason for this visit: _____

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

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur/MVP
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Current Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Tobacco
- ☐ e-Cigs

OTHER:
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- What prescription medications do you presently take? _____
- What over the counter and/or dietary supplements do you take? _____
- Do you have any known drug allergies? _____

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: _____
Signature of patient, parent or guardian

Referral Information

How did you hear about our practice? ☐Another patient ☐Dental office ☐ Yellow Pages ☐Advertisement ☐ Internet search

Name of person/office/website referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

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

Social Security #: _____ Date of birth: _____

Phone: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
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 Phone

Dental Insurance Information

If you have a physical copy of your insurance card, you do not need to fill this out

Primary

Name of Insured: _____ 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 _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ 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 _____

Insurance Plan Name and Address: _____

_____

Consent for Services

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.

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.

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 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 at home, cell, or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 90 days from date of service, you will be expected to pay the balance in full. As a courtesy to you we will help you process your insurance claims. In order for our office to file your insurance claim, you must bring proof of insurance.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks, and all major credit cards. Outside financing is available through CareCredit and/or Lending Club upon request and approval.

Returned check fee charge is $35.00.

Additionally, our office has the right to charge you for appointments that you do not keep and for appointments that you do not cancel with 48 hour notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

_____ _____

Print name of patient or responsible party Signature

BROKEN APPOINTMENTS

As we try to be respectful of your time, we also ask you to be mindful of our time and be prompt for your appointments. We try our best to run on schedule, but we are unable to do that if our patients aren't here on time. If you are more than 10 minutes late, we may have to reschedule your appointment.

We kindly ask you to give us 24 hours notice if you are unable to keep an appointment. This allows us to fill our schedule with other patients who may be waiting.

A broken appointment is an appointment that is rescheduled or cancelled with less than 24 hours notice. We understand that illness, emergencies, flat tires, and bad weather do occur. We allow one broken appointment. After the first one, we will charge a fee for any other broken appointments. It is our office policy to discontinue seeing a patient after three broken appointments.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services affordable. The appointment you schedule is reserved for you and your treatment only. When you fail to keep you appointment without providing adequate notice, this adds to the overall cost of care, as trained professional and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy. If you have any questions or concerns, never hesitate to ask.

I have read and understand the above policy.

_____

Signature

Patient Name: _____ Date: *10/10/2019*

Last, First MI (Preferred Name)

E-Mail Address: _____

Consent for Internet Communications

I grant my permission to «Practice_Name» to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for «Practice_Name». I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand «Practice_Name» and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that «Practice_Name» 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 «Practice_Name» 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 entity to access and use the «Practice_Name» web site with my ID and password. I also agree to immediately notify «Practice_Name» of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand 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 «Practice_Name» 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 patient 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 «Practice_Name» has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand «Practice_Name» will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand «Practice_Name» CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for «Practice_Name», and grant «Practice_Name» permission to securely upload my patient information to the web site.

_____ _____ _____

Signature of patient, parent or guardian Date Relationship to the patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(available at the front desk upon request)

I have reviewed this office's Notice of Privacy Practices.

_____

Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify) _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of birth: _____

Telephone: _____ E-mail: _____

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. 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 the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this 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.

SIGNATURE

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 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 a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

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