Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ (Last Name / First Name / Initial) Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____ (Last Name / First Name / Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

Medical History

Physicianís Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Latex Sensitivity ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Keith Kye, DDS, PA
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Keith Kye, DDS, PA is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointments
☐ Other person (s) (provide name and phone number)(i.e. Spouse, Parent, Grandparent, Stepparent, Friend etc.) ☐ _____ ☐ _____ ☐	☐ Financial ☐ Treatment/ Treatment Plans
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment/ Treatment Plans ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2014

{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

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)

_____

_____

_____

KEITH A. KYE, DDS, FAGD Updated 8/2013

Financial Guideline

At our office, we strive to provide service beyond expectation for all of our patients. We always want to inform our patients before treatment is rendered so there are no surprises or financial burdens incurred. It is our passion to help you afford the treatment you desire.

In order to serve you better and keep costs at a minimum, we request your portion of the dental services the day of your appointment. There are a number of options from which you can choose to pay for your dental visit. We accept Master Card/Visa, American Express, Discover, cash, and checks. We offer an interest free monthly payment option through Care Credit as well. There is a return check fee of $30.00.

Insurance Information

For your convenience, we will gladly file your insurance forms electronically, at no charge. This enables a faster response from your insurance carrier.

Many "preferred provider" type insurance companies dictate that only the lowest quality materials and treatments are adequate for their subscribers. We disagree. We know that all of our patients deserve to be treated equally and be given all options when treatment is necessary. It is then left to you to decide what may be right for you, and not your insurance company. The relationship between you and your dentist should be just that, and not between your dentist and an insurance company. We will however, be glad to assist you while working with your insurance company to maximize any benefits you have. We are committed to helping you in any way we can, with or without insurance. In network or out of network. We are in network with Delta Dental Premier, Cigna Core Network, and Metlife.

AFTER 60 DAYS FROM THE DATE OF SERVICE, YOU ARE RESPONSIBLE FOR THE UNPAID BALANCE IF WE HAVEN'T RECEIVED PAYMENT FROM YOUR INSURANCE COMPANY.

Appointments

If for any reason it is necessary to cancel an appointment, please call **48** (business) hours in advance, otherwise we reserve the right to charge **$25 or 10% per appointment.**

I have reviewed and understand these financial guidelines _____

Signature / Date

EPWORTH SLEEPINESS SCALE SCREENER

Name:_____DOB:_____
Phone Home:_____Work:_____Cell:_____
Address:_____
City, State, Zip:_____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Even if you have not done some things recently, try to work out how they would have affected you. Use the scale below to choose the most appropriate number for each situation. Write the numbers on each line and a staff member will add them up on the total line.

SCALE FOR CHANCE OF DOZING: 0=never 1=slight 2=moderate 3=high

Situation:	**Chance of dozing**
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (theater, meeting)	_____
Sitting as a passenger in a car for an hour w/out break	_____
Lying down to rest in the afternoon when permitted	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
Sitting in a car while stopped for a few minutes (traffic)	_____

TOTAL SCORE:_____

Please Circle all that apply.

Do you snore loudly or does it bother your bed partner?	YES NO
Are you excessively tired or sleepy during the day?	YES NO
Have you been told you stop breathing during sleep?	YES NO
Do you wake during the night feeling breathless or gasping?	YES NO
Do you wake up feeling un-refreshed after a night's sleep?	YES NO
Do you have a history of hypertension (high blood pressure)?	YES NO
Male gender or Menopausal Female?	YES NO
Do you have trouble going to sleep or staying asleep?	YES NO

Epworth Sleepiness Scale of 10 or greater or "YES" to four (or more) of the circled questions is a positive screen for sleep disordered breathing. A member of our staff will discuss this score with you, and we also recommend you consult with your primary care physician regarding the need to have a sleep study performed to diagnose any sleep disorder.

Patient Signature:_____Date:_____

Dr Keith Kye 8936 Northpointe Exec Park Dr. Suite 120 Huntersville, NC 28078 (704) 896-0515

Keith A. Kye, DDS, FAGD
General and Cosmetic Dentistry

SMILE QUESTIONNAIRE

Full Name:

Please circle the answer to the following questions:

Is there any part of your smile you would like to change? Y/N

Would you like your teeth to be whiter? Y/N

Do you have any gaps between your teeth you would like corrected? Y/N

Are you happy with the alignment of your teeth? Y/N

Any discolored or silver fillings you don't like appearance of? Y/N

Do you have any old crowns you don't like, or crowns with black lines at the gumline? Y/N

please explain_____

Do you have any missing teeth you would like replaced? Y/N

Please let us know if there are any reasons why you are unhappy with your smile:

_____

_____

_____

_____