Kyle G. Keeter D.D.S
Cosmetic & Restorative Dentistry

Today's Date: _____

Last Name: _____ First Name: _____ MI:_____

Circle One: Dr. Mr. Mrs. Miss Ms. Preferred Name: _____

Address: _____ City: _____State:_____ Zip: _____

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

Email Address: _____ DOB: _____ Social Security No. : _____

Employer: _____Position/Title: _____No. of Yrs: _____

Spouse's Name: _____ Phone: _____

Guardian's Name (If minor): _____ Phone: _____

Emergency Contact: _____ Phone: _____

Other family members seen by us: _____

Referred by: _____

Do you have dental insurance? Y N

If you have dental insurance through someone else other than yourself, please provide their information below:

Name: _____ Employer: _____

Social Security No. : _____ DOB: _____

MEDICAL HISTORY

Physician's Name: _____ Date of last exam: _____

Please list any prescription/over the counter medications you are taking:

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Please circle if you have ever had any of the following diseases or medical conditions:

Y N Aids/HIV Positive
Y N Allergies
Y N Anemia
Y N Cancer/Chemo/Radiation (circle)
Y N Diabetes
Y N Eating Disorder
Y N Epilepsy/Seizures
Y N Glaucoma
Y N Heart murmur/Mitral valve prolapse
Y N Heart problems/Chest pains
Y N Hepatitis (A,B,C circle one)
Y N Herpes
Y N High blood pressure
Y N Kidney/Urinary problems
Y N Low blood pressure
Y N Pacemaker
Y N Rheumatic/Scarlet fever (circle)
Y N Sinus problems
Y N Stomach/Digestive problems
Y N Stroke
Y N Tobacco use (what form?) _____
Y N Ulcer

Y N Have you taken an oral or I.V. bisphosphonate drug? (i.e. Fosamax, Actonel, Boniva, etc.)

Y N Have you had a joint replacement surgery? What type? _____

Y N Are you pregnant or nursing?

Please list any other medical condition(s) that we should be aware of: _____

_____

Have you had an undesirable or allergic reaction to:

Y N Aspirin
Y N Latex
Y N Dental anesthetics
Y N Pain medication(List) _____
Y N Antibiotics (List) _____
Y N Other _____

Name of previous dentist: _____ Date of last dental visit: _____

Have you had dental X-rays taken in the past year? Y N Date of last cleaning: _____

What is the purpose of your dental visit today? _____

Do any of the following apply to you?

Y N Discomfort in the mouth
Y N Bad odor or taste
Y N Have partials/Dentures
Y N TMJ (jaw joint) problems
Y N Grinding or clenching
Y N Have a night guard
Y N Sores or growths in mouth
Y N Frequent headaches
Y N Dry mouth
Y N Orthodontic treatment
Y N Gum recession
Y N Bleeding gums
Y N Is your present dental health good?
Y N Snoring/Sleep apnea
Y N Use CPAP_____ Snore Appliance _____
Y N Are your teeth sensitive to:
___Heat ___ Aches spontaneously
___Cold ___ Pressure___ Pain when biting

How many times a day do you brush? _____ How often do you floss? _____

Have you had previous bad experiences with dentistry? _____

What, if anything, would you change about your teeth/smile if you could? _____

_____

Y N Are you interested in straightening your teeth?

Y N Do you think your teeth could be whiter?

Are there any concerns or topics you wish to discuss in detail? _____

_____

The information provided today is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I understand that I'm responsible for all charges in full at the time of service unless prior arrangements have been approved.

_____

Patient Signature Date

Dr. Kyle G. Keeter, DDS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of Dr. Kyle Keeter's Notice of Privacy Practices and have read and understand this information.

_____
Name

_____
Signature

_____
Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you have reviewed and understand our Notice of Privacy Practices and give consent to use and disclose your protected health information that may be used for treatment, payment or healthcare operations.

We reserve the right to change the privacy policy as allowed by law. You have the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointment?	YES	NO
May we leave a message on your answering machine at home or on your cell?	YES	NO
May we discuss your dental conditions with any persons other than yourself?	YES	NO

If **YES**, please list names below:

NAME _____ RELATIONSHIP: _____

NAME _____ RELATIONSHIP: _____

NAME _____ RELATIONSHIP: _____

This consent was signed by: _____
(PRINT NAME)

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: _____

Dr. Kyle G. Keeter, DDS

NOTICE OF PRIVACY PRACTICES

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information.

You may request a copy of our notice at any time. We reserve the right to make changes to our privacy practices. You have the right to request that we amend your health information

USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

We use and disclose health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use and disclose your health information to obtain payment for services we provide to you. We may use and disclose your health information in connection with our health care operations.

AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other persons but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post cards, electronic communication, or letters).

PATIENT RIGHTS: You have the right to look at or get copies of your health information. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your health information.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain activities.

RESTRICTIONS: You have the right to request that we place additional restrictions on or use or disclosure of your health information.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations.

ELECTRONIC NOTICE: If you receive this notice on our website or by electronic mail (e-mail) you are entitled to received this notice in written form.

If you are concerned that we may have violated your privacy rights, you may submit a written complaint to:
U.S. Department of Health and Human Services.
200 Independence Avenue, S.W. Washington D.C., 20201 1-877-696-6775