PAUL YAGGIE, DMD

Date: _____

PATIENT INFORMATION:

_____

Last Name First Middle Maiden Name

_____

Home Address Mailing Address (If Different)

_____

City State Zip Code

_____

Date of Birth Sex Social Security No. Home Phone Cell Phone

_____

Driver's License No. State of Issue Email Address Marital Status

_____

Place of Employment Occupation Work Phone

_____

Spouse/Parent Home Address Social Security No.

_____

Spouse/Parent Place of Employment Occupation Date of Birth Work Phone

Other Family Members Seen in Our Office _____

Referred By: _____

INSURANCE INFORMATION (Please Give Your Insurance Card To The Receptionist)

_____

Patient's Relationship to Subscriber Name of Dental Insurance Company

_____

ID No.. Group # Address of Insurance Company

_____

City State Zip Code

IN CASE OF EMERGENCY

_____

Name of Local Friend or Relative (Not living at same address) Relationship to Patient Home Phone Work Phone

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment of any services rendered prior to those services being performed. I also authorize Dr.Yaggie, his staff or insurance company to release any information required to process my claims. You must realize that your insurance company has an obligation to you and not to the dentist. This office has no contractual arrangements with insurance carriers, unions, or managements; therefore you are responsible to us for payment of services render

_____ _____

PATIENT/GUARDIAN SIGNATURE (RQUIRED) DATE

Please bring all documents with you at the time of appointment or e-mail them directly to us by submitting online.

Paul Yaggie, D.M.D.,
1727 Sadie Lane Apt. 7
LOUISVILLE, KY. 40216
(502) 327-6002

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name_____ Date of Birth_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice Provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with the respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purpose: treatment, payment and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint .
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice Of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's Notice of Privacy practices on request.

Signature:_____ Date: _____

Relationship to patient (if signed by a personal reprehensive of patient):_____

Please bring all documents with you at the time of appointment or e-mail them directly to us by submitting online.

Dr. Paul Yaggie
Financial Responsibility

Dental treatment is an excellent investment in an individual's health and well being. Because of this, we believe financial considerations should not be an obstacle to obtaining this investment. **PAYMENT AT TIME OF SERVICE IS EXPECTED**. In situations involving large treatment plans and / or insurance benefits; we provide two payments options. We are sensitive to the fact that different patients have different needs, so the following are the financial options available to our patients.

CASH, CHECK OR CREDIT CARDS: We accept cash, personal and certified checks as well as **VISA, MASTER CARD, DISCOVER AND AMERICAN EXPRESS**. If we carry the balance it is subject to 15% APR.

***IF PATIENT PREFERS TO HAVE AUTOMATIC DEBITS TO CREDIT OR DEBIT CARDS, AN AUTHORIZATION FORM MUST BE ON FILE IN THE PRACTICE.**

LOW MONTHLY PAYMENT PLANS

Our office currently uses an outside billing agency. These are specifically designed for dentistry and related specialties- with low monthly payments. (Subject to Approval)

- Interest free options available (3,6,12 and 18 months)
- No initial payments
- Low, fixed rates ranging up to 13.95% ARP
- Low monthly payments
- No prepayment penalty, terms up to 60 months
- Quick and easy application process. Same day approval!

DENTAL INSURANCE PATIENTS:

I understand my dental insurance is a contract between the insurance carrier, and myself. Not between Dr. Paul Yaggie and the insurance carrier. As such I understand that I am responsible for the full amount of all dental fees incurred. Any payments received by Dr. Paul Yaggie from my insurance carrier will be credited to my account or refunded to me **IF** I have paid the dental fees incurred.

INSURANCE COVERAGE

Our practice will be happy to assist you in determining whether your insurance company will cover dental services. If your company does provide a benefit, our team will be happy to assist in filing your claim. After your initial visit and diagnosis of treatment, our office Financial Coordinator will discuss with you what benefits your insurance company provides. If needed, a pre-treatment estimate will be sent to your insurance company to determine what benefits you will receive. Patients are responsible for any portion not covered by insurance and those amounts are due at time of service.

I understand that the payment of my bill is my legal obligation as the patient. I further agree to pay returned check charges of $30.00 per returned check. IF this account is placed in the hands of a outside collection agency, I agree to pay the fees incurred by that agency in regards to the collection process.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

OFFICE ADMINISTRATOR SIGNATURE DATE

Please bring all documents with you at the time of appointment or e-mail them directly to us by submitting online.

AS YOU KNOW, APPOINTMENT TIMES ARE VALUABLE! THEREFORE, WE ASK THAT YOU NOTIFY OUR OFFICE IN THE EVENT YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOIMTMENT.

(24 HOURS IS REQUIRED)

I UNDERSTAND THERE IS A $75.00 AN HOUR "BROKEN APPOINTMENT FEE" IN THE EVENT I DO NOT NOTIFY THE OFFICE 24 HOURS PRIOR TO THE APPOINTMENT TIME.

SIGNATURE OF PATIENT _____.

SIGNATURE OF PARENT _____.
(IF PATIENT IS A MINOR)

EMAIL _____.

Please bring all documents with you at the time of appointment or e-mail them directly to us by submitting online.

Paul Yaggie D.M.D.
Dental History

Please complete the following Questionnaire and bring it with you to your appointment

Patient Name_____ Date_____

Who were you referred by: _____ Why_____

How long have you been seeing your current dentist? _____

When was your last dental visit? _____/____/____ What was done? _____

Who was your previous dentist? _____ How often do you have your teeth cleaned? _____

Have you ever been treated for periodontal disease? ____ If so, when and who was the Dentist? _____

How often do you brush? _____ How often do you floss? _____

What Type of Toothbrush do you use? ___Manual ____Electric (what type? _____

What type of bristles does it have? ___Soft ____Medium ____Hard

Do you use tobacco? __Y __N if yes, what type? (Cigarettes, Pipe, cigars, smokeless tobacco)
If cigarettes, how many packs per day? _____ How many years? _____ would you be interested in methods and or medication to help you quit? _____ yes ____ no

DO YOU HAVE OR HAVE YOU HAD:

___Pain? If yes, Where? _____ How long_____
Describe the pain: Throbbing, Burning, Shooting, ect._____
What makes it worse Heat, Cold, pressure, ect. _____
Is there anything that relieves the pain? _____
___Orthodontic treatment (braces)? What age_____ By whom? _____
___ Serious injury to the mouth or head? Please describe_____
___ Do your gums bleed when you brush?
___Sensitive Teeth? What makes them sensitive? Cold, Sweets, etc._____
___Missing teeth? Are you interested in replacing these teeth? _____
___Complete or partial dentures? Are they lose____ Would you be interested in ways to replace them or improve their fit?
___Trouble chewing food? Why? _____
___Frequent Headaches? Have you seen a medical doctor? _____
___Clicking or popping of the jaw? ___Difficulty in opening or closing mouth?
___Difficulty in chewing on either side of the mouth? ___Neck aches or shoulder aches?
___Sore muscles (especially in the neck or shoulder?) ___Pain near the joint, ear or side of face?
___Dissatisfaction with the appearance of your teeth? Why? _____
___Anxiety toward Dentists? Rate your anxiety on a scale of 1 to 10 (10 being worst) _____

DO YOU HAVE ANY OF THE FOLLOWING

___Teeth clenching or grinding ___Check Biting ___ Bad Breath ___Breathing through your mouth
___Frequent cold sores, Fever blisters or any other oral lesions? ___Dry Mouth___Excess use of mint candies and chewing gum ___Frequent use of toothpicks ___Brushing with heavy pressure ___Snoring

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