Pediatric Patient Information

Today's Date ___________________

Patient's Name: ____

Preferred Name: ____________________________ Date of Birth: ______________________

Address: ____

School Attending (if applicable): ____

Father's Name: ________________________Mother's Name: __________________________

Person Financially Responsible/Relationship: __________________________________

Dental Insurance Company: ____

Secondary Dental Insurance Company: ____

Who may we thank for referring you? ____

Child's Interests (Sport/Hobby/Show/Book): ___________________________________

By signing below, I guarantee that the information presented above is accurate.
By signing below, I give this office permission to submit information to the insurance company(s) listed above and to collect fees for the services provided.
By signing below, I agree that I am responsible for all fees not paid by my insurance including but not limited to deductibles, co-pays, non-covered services, and disallowed services; any interest or fees assessed to my account for past due balances, returned checks, and any and all fees incurred as a result of the use of a collection agency.

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Parent/Guardian Signature Date

Child's Health History

Patient's Name: ____**Today's Date:** ______________________

Name of child's physician: ________________________________ **Phone #:** ________________________

Has your child ever been hospitalized? ☐ yes ☐ no **Ever had surgery?** ☐ yes ☐ no

If yes, please explain: ____

Please check if your child has been diagnosed or treated for the following:

☐ Acid Reflux
☐ ADD/ADHD
☐ ASD
☐ Asthma
☐ Cancer/tumor
☐ Cerebral palsy
☐ Cleft lip/palate
☐ Cold/canker sores
☐ Diabetes
☐ Developmental delays
☐ Eating disorder
☐ Epilepsy/seizures
☐ Hearing impairment
☐ Heart murmur/defect/surgery
☐ Hemophilia/bleeding disorder
☐ Metabolic disorder
☐ Psychiatric care
☐ Sleep apnea
☐ Speech disorder
☐ Stomach/GI disorder
☐ OTHER:

____

Medications: ____

Allergies: ____

Please note that it is your responsibility to update any changes to your child's health information.

____
Parent/Guardian Signature Date

Child's Dental Health History

Patient's Name: ____**Today's Date:** _______________________

Date of last dental visit: ________________ **Previous Dentist:** __________________________________

Does your child have a specific dental problem that needs attention? yes ☐ no

If yes, explain: ____

Has your child ever complained about any dental problems? yes ☐ no

If yes, what? ____

Has your child ever had an unhappy dental experience? ☐ yes ☐ no

If yes, explain: ____

Has your child ever had any injuries to their mouth/teeth/head? ☐ yes ☐ no

If yes, explain: ____

Has your child seen an orthodontist? ☐ yes ☐ no

Has your child ever worn any orthodontic appliances? ☐ yes ☐ no

How often does your child brush? ____

Does your child floss? ☐ yes ☐ no

Do you assist your child when brushing/flossing? ☐ yes ☐ no

Is fluoridated toothpaste used? ☐ yes ☐ no ☐ I don't know

Does your child currently:

☐ Breastfeed ☐ Bottle feed ☐ Use sippy cups
☐ Thumb/finger suck ☐ Use pacifier ☐ Bite nails
☐ Grind teeth ☐ Mouth breathe ☐ Snore
☐ Tongue thrust ☐ Take a bottle/cup to bed

Does your child receive:

☐ Tap water ☐ Bottled Water ☐ Well Water
☐ Fluoride Rinse ☐ Fluoride Tablets

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Parent/Guardian Signature Date

Office Policy

Payment is due at the time service is provided, unless previous arrangements have been made. Our office accepts cash, check, VISA, MasterCard, Discover, American Express, and Care Credit.

If you have dental insurance, as a courtesy, we will assist you in processing claims on your behalf. In order for our office to file your insurance claim, you must bring your insurance card to each appointment and alert our office to any changes in your insurance provider or policy. Any co-payment that is the patient's responsibility is due when the service is provided unless other arrangements have been made.

If you are unable to keep a scheduled appointment, please contact our office 2 business days in advance. In the event of multiple missed or broken appointments, our office reserves the right to assess a fee on the patient's account.

In the event the patient (or family member) has a balance on their account, a billing statement will be mailed. If no payment is made on the account before the due date, a re-billing fee may be assessed for subsequent billing statements.

If you have any questions regarding our policy, please do not hesitate to ask.

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Patient Signature Date

Joseph Keck DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name:____

Address:____

Telephone:_________________________ Social Security No.______________________

Section B: **TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

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 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 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.

You may obtain a copy of our notice of privacy practices, including any revisions of our notice, at any time by contacting:

Contact Person: Tammy Threlkeld Telephone: 765-436-2433 Fax: 765-436-2551

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand the 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 and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare 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.