TIME 08:29 AM

DATE 2/2/2026

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Gender: ☐ Male ☐ Female ☐ Unknown Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

DIQ, _____

PIQ, _____

Cell Phone # _____

E-mail address _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Time 8:24 AM

Kevin M. Killian, D.D.S., P.C.

Date 2/2/2026

Dr. Killian (Welcome to our our Practice)

Patient Name:

Birth Date:

Date Created:

Insurance Information

Dr. Killian is a non-participating provider for all HMO-PPO insurance companies.As a courtesy we will file claims with your insurance on your behalf. Our office will estimate and collect patient portions on the date of service.

Employer Sponsored Dental Insurance
I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. Your dental insurance is a benefit provided by your employer. Usual, customary and reasonable (UCR) / Fee schedules differ with each insurance company, often those premiums are a negotiated costs between your employer and the insurance being offered. It is not uncommon to pay a portion for preventive care with some of these insurance companies. A certain policy may read preventive care covered at 100%. But actually it's 100% of any allowed fee.

We accept Cash, Checks, Visa, MasterCard, Discover,and American Express as well as Care Credit.

If you have any questions regarding Care Credit please speak with any of our staff members.

Appointment Reminders

Please be advised that our office requires at least 48 hour notice when changing your dental appointment.
Our e-mails, texts, and phone calls are a courtesy reminder and not the time to change or cancel.
Any last minute changes could best be served by other patients waiting to receive dental treatment.
We do understand emergencies arise, in those cases please notify our office by calling as soon as possible.
Do not send email/text to cancel your appointment. Chronic failed / re-scheduled appointments will be charged a fee of $54.00 per half hour and future appointment times may not be reserved.

Billing

I guarantee payment of all said charges incurred in accordance with the policy of payment of bills. Interest on the unpaid balance, at the rate of eighteen percent (18%) per annum, will be accrued 45 days after services rendered. In the event the account must be placed with an attorney or collection agency to obtain payment, I shall be responsible for all attorney and collection fees incurred.

Permission To Treat

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dental professional.

I hereby authorize payment of insurance benefits directly to the dentist group, otherwise payable to me.

I HAVE READ AND UNDERSTAND ABOVE

Signature of Patient, Parent or Guardian:

X

Date:

Kevin M. Killian, D.D.S., P.C.

Dr. Killian Patient Medical History (Copy)

Patient Name: Birth Date: Date Created:

Medical Doctor

Physician's Name		
Address		
Phone Number		
When was your last complete physical exam?		
Are you under your physician's care for any thing other than routine care?	○ Yes ○ No	If yes

Health History

Are you taking any medication or substances?	○ Yes ○ No	If yes
Are you taking a blood thinner?	○ Yes ○ No	If yes
Do you routinely take health related Vitamins, Herbal / Natural supplements?	○ Yes ○ No	If yes
Have you ever had a serious illness or majory surgery?	○ Yes ○ No	If yes
Women - Are you Pregnant? How far along are you?	○ Yes ○ No	If yes
Women- Do you use any birth control medication?	○ Yes ○ No	If yes
Have you taken Fosamax, Zometa, Aredia (bisphosphonates) ?	○ Yes ○ No	If yes
Do you have a form of Arthritis?	○ Yes ○ No	If yes
Do you smoke, use snuff, or other forms of tobacco?	○ Yes ○ No	If yes
Do you consume more than one or two alcoholic beverages a day?	○ Yes ○ No	If yes
Do you habitually use controlled substances?	○ Yes ○ No	If yes
Do you need to premedicate prior to dental care? (Heart Valve Replacement) (Artificial Joint Replacement)	○ Yes ○ No	If yes

Have you taken any prescription drugs for weight loss?

Fenfluramine ○ Yes ○ No	Fenfluramine W/ Phentermine(Fen-Phen) ○ Yes ○ No	Dexfenfluramine (Redux) ○ Yes ○ No

Is there anything you would like to discuss privately with Dr. Killian?	○ Yes ○ No	If yes

Check Appropriate

Are you allergic to

Penicillin	○ Yes ○ No	Metals	○ Yes ○ No	latex	○ Yes ○ No	Other Antibiotic Drugs	○ Yes ○ No
Sulfa Drugs	○ Yes ○ No	Local Anesthetics	○ Yes ○ No	Lactose	○ Yes ○ No	Red Dye	○ Yes ○ No

Are you allergic to any medication / substance not listed?	○ Yes ○ No	If yes
Do you have a food allergy?	○ Yes ○ No	If yes

Do you have any of these related health conditions? Please check all that apply

Heart Disease	○ Yes ○ No	Pacemaker	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Stroke	○ Yes ○ No
Heart Murmurs	○ Yes ○ No	Rheumatic fever	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Radiation/Chemo	○ Yes ○ No	Anemia	○ Yes ○ No	Leukemia	○ Yes ○ No	Diabetes	○ Yes ○ No
Kidney problem	○ Yes ○ No	Liver problem	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting / Dizzy spells	○ Yes ○ No
Epilepsy/Seizure	○ Yes ○ No	Stomach Problems	○ Yes ○ No	Psychiatric Treatment	○ Yes ○ No	Breathing Problems	○ Yes ○ No
Hepatitis	○ Yes ○ No	Bleed Excessively	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Drug/Alcohol Addiction	○ Yes ○ No	HIV / AIDS	○ Yes ○ No	Sexually Transmitted Disease	○ Yes ○ No		

Do you have any disease, condition or health related problem not listed on this form?	○ Yes ○ No	If yes

I CERTIFY THE INFORMATION IS COMPLETE AND ACCURATE

Signature of Patient, Parent or Guardian:

X Date:_____

AUTHORIZED BY

Signature of DENTIST SIGNATURE:

X Date:_____

Kevin M. Killian, D.D.S., P.C.

Dr. Killian Patient Dental History (Copy)

Patient Name: (25482) Christy Henke Birth Date: 9/19/1975 Date Created: 2/2/2026

Check the Appropriate

Purpose of initial visit?		Comment	
Are you aware of a problem?	○ Yes ○ No	If yes	
How long since your last dental visit?			
What was done at that time?		Comment	
Previous dentist's name		Comment	
When was the last time your teeth were cleaned?			
Have you made regular visits?	○ Yes ○ No		
Were dental x-rays taken?	○ Yes ○ No	If yes	
Have you lost any teeth or have any teeth been removed?	○ Yes ○ No	If yes	
Have they been replaced? How?	○ Yes ○ No	If yes	
Are you unhappy with the replacement?	○ Yes ○ No	If yes	
Would you like to know about permanent replacements?	○ Yes ○ No	If yes	
Have you ever had any problems/complications with previous dental treatment?	○ Yes ○ No	If yes	
Do you clench or grind your teeth?	○ Yes ○ No	If yes	
Does your jaw click or pop?	○ Yes ○ No	If yes	
Have you experienced any pain or soreness in the muscles around your face/ear?	○ Yes ○ No	If yes	
Do you have frequent head, neck or shoulder aches?	○ Yes ○ No	If yes	
Does food get caught in your teeth?	○ Yes ○ No	If yes	
Are any of your teeth sensitive to: Hot, Cold, Sweets, Pressure?	○ Yes ○ No	If yes	
Do your gums bleed or hurt?	○ Yes ○ No	If yes	
Do you experience dry mouth?	○ Yes ○ No	If yes	
How often do you brush your teeth and when?		Comment	
Do you use dental floss? How Often?	○ Yes ○ No	If yes	
Are any of your teeth loose, tipped, shifted or chipped?	○ Yes ○ No	If yes	
Are you unhappy with the appearance of your teeth?	○ Yes ○ No	If yes	
Do you feel your breath is offensive at times?	○ Yes ○ No	If yes	
Have you had any gum treatment or surgery?	○ Yes ○ No	If yes	
Have you had any unpleasant dental experiences?	○ Yes ○ No	If yes	
Have you had any orthodontic work?	○ Yes ○ No	If yes	

I CERTIFY THAT THE INFORMATION IS COMPLETE AND ACCURATE

Signature of Patient, Parent or Guardian:

X Date:

AUTHORIZED BY

Signature of DENTIST:

X Date:

Kevin M. Killian D.D.D.

625 Salt Lick Road

St. Peter's Mo 63376

Dr. Killian's primary focus is to help you maintain good oral health. Our office provides quality dental care for our patients, in the highest standards of safety and infection control. We strive toward continual improvements and education for the staff members to better serve our patients.

Dr. Killian is a non-participating provider for all HMO, PPO, and Medicare Advantage plans. As a courtesy our office accepts Assignment of Benefits on your behalf. What that means is, in lieu of paying for services received in full, we file a claim on your behalf and accept the monies otherwise payable to you for those services.

Please note our office tries our best to estimate patient portions at the date of service and collect those portions based on the **information received by your insurance company with the disclaimer that it is not a guarantee of eligibility, benefits or payment. Contacting your insurance about your policy is always best.**

Your dental benefits are a contract agreed upon between you and your insurance company or employer offering the insurance. Our office cannot accept responsibility for procedures not covered by your plan. Dr. Killian treats his patients based on dental needs and oral health, not what a policy covers.

To keep our costs down we try to avoid billing expenses. If there is a remaining balance left unpaid we ask that it be taken care of in a timely manner. Accounts that are not taken care of in a timely manner with multiple efforts to collect will result in paying for your services in full.

Please feel free to reach out with any questions regarding assignment of benefits and estimated portions collected with our front office coordinators.

_____ _____

Patient / Guardian Signature Date

Kevin Killian D.D.S

625 Salt Lick Road

St. Peters, MO 63376

(636) 978-2699

I hereby authorize the office of Kevin Killian D.D.S. to charge the card number listed for any charges remaining on my account after dental insurance pays. To terminate this billing process I understand that I must do so in writing and have no outstanding insurance claims awaiting payment. I guarantee that I am the legal cardholder for this credit card account and that I am legally authorized to use it.

Card Holder Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Type: _____ Card Number: _____

Credit Card Security Code: _____ Expiration _____

Signature of Card Holder: _____

Please call if remaining amount is over: _____ Date: _____

List of family member's on account:

_____ _____

_____ _____

_____ _____

_____

[Insert Name of Practice]

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____ , acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Dr. Kevin Killian

625 Salt Lick Road

St. Peters, MO 63376

HIPAA WRITTEN AUTHORIZATION TO APPOVED FAMILY/ OTHER PERSONS

On your authorization:

You may give us written authorization to disclose to persons listed below your health care information. You may revoke this authorization in writing at any time. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in our notice of privacy practices.

Below please list name of person / persons you are authorizing this approval to and your relationship.

_____ _____

Name of Person Relationship

_____ _____

Name of Person Relationship

_____ _____

Name of Person Relationship

_____ _____

Signature Date