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: _____

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- Child Medical/Dental Form

Patient Name: Birth Date: Date Created:

Medical Section

Does your child have any Health problems?	Yes No	If yes	
Is your child under the care of a Physician? Why?	Yes No	If yes	
Name of Physician?		Comment	
Is your child receiving any medication?	Yes No	If yes	

Is your child allergic to

Penicillian	Yes No	Other Antibiotic Drugs	Yes No	Metal	Yes No
latex	Yes No	Asprin	Yes No	Motrin	Yes No
Sulfa Drugs	Yes No	Local Anesthetics	Yes No		

Any other allergies we need to be aware of?	Yes No	If yes	

Has your child had a history of

Diabetes	Yes No	Heart Trouble	Yes No	Asthma	Yes No
Kidney infection	Yes No	Rheumatic fever	Yes No	Epilepsy	Yes No
Cerebral Palsy	Yes No	Liver Problems	Yes No	Congenital Birth Defects	Yes No
Cognitive Disability	Yes No	Eyesight Problems	Yes No	Cancer	Yes No
Infections	Yes No	Speech Impairments	Yes No	Hearing Loss	Yes No
AIDS	Yes No	HIV Positive	Yes No	Hepatitis	Yes No
Fainting	Yes No	Seizures	Yes No	Dizziness	Yes No
Behavioral/Learning Problems	Yes No	Heart Murmur	Yes No	Prolongated Bleeding	Yes No

Is there any other health concerns not listed we need to be aware of?	Yes No	If yes	

Dental Section

Is this your child's first visit to a dentist?	Yes No		
If not, how long since the last visit to the dentist?			
Where any x-rays taken at that time?	Yes No		
Does your child eat between meals?	Yes No		
Does your child eat sweets, such as candy, soda, chewing gum?	Yes No		

When does your child brush his/her teeth?

Upon arising	Yes No	After eating food	Yes No	Right after meals	Yes No
Before going to bed	Yes No				

How does your child receive Fluoride?

Community water	Yes No	Well water	Yes No	Fluoride drops or tablets	Yes No
Fluoride rinse or gel	Yes No				

Have any cavities been noted in the past?	Yes No	If yes	
Does your child suck his/her thumb or fingers?	Yes No	If yes	
Have any baby or permanent teeth been removed by extraction?	Yes No	If yes	
Was it suggested that the space be maintained?	Yes No	If yes	
Was an appliance placed?	Yes No	If yes	
Have there been any injuries to teeth, such as falls, chips, ect?	Yes No	If yes	
Has your child had any problem with dental treatment in the past?	Yes No	If yes	
Had anyone in the family, including parents, had orthodontics?	Yes No	If yes	
Has your child ever received a local anesthetic?	Yes No		
Has your child ever had occlusal sealants?	Yes No		
Does your child think there is anything wrong with his/her teeth?	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 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