_____

[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. 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.

625 Salt Lick Road

St. Peters, 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 improvement and education for the staff members to better serve our patients.

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 moneys otherwise payable to you for those services.

Our office tries our best to estimate patient portions at the date of service and collect those portions. Unfortunately, until a claim is processed by your insurance company and they have reviewed your benefits, exclusions, frequencies, pre-existing conditions and provisions, those amounts will vary.

Some plans pay on Usual Customary and Reasonable Fees known as (UCR) and others pay on Max Allowable Schedule as well as other cost control measure such as claim bundling, down coding, and least expensive alternative treatment. You are the responsible party for any remaining balance not covered under your plan.

Your dental benefits are a contract agreed upon between you and your insurance company or employer. Please understand, we do our best to discover dental benefits as a service to our patients and cannot accept responsibility for procedures that are not covered by your insurance company. We recommend you get to know your policy and we are always available to answer any questions. Contacting your insurance about your dental benefits is always best.

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 will result in paying for your services in full.

_____ _____

Patient / Guardian Signature Date

_____

Patient / Guardian (PRINT)

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
Befere 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:_____

Time 11:30 AM | Kevin M. Killian, D.D.S., P.C. | Date 5/31/2022

Dr. Killian Patient Dental History (Copy)

Patient Name: | Birth Date: | Date Created:

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:_____

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

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:_____

[Insert Name of Practice]

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Provider Contact Office: _____

Telephone: _____ Fax: _____

E-Mail: _____

Address: _____