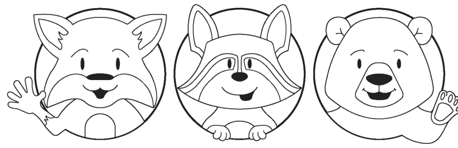

Pediatric Dentistry
OF KELLER

Patient Information

Date_______________

1. Name of Child____ Sex: M F
Last Name First Name Middle Initial
Date of Birth_____________________________ School Name ____

2. Name of Child____ Sex: M F
Last Name First Name Middle Initial
Date of Birth_____________________________ School Name ____

3. Name of Child____ Sex: M F
Last Name First Name Middle Initial
Date of Birth_____________________________ School Name ____

4. Name of Child____ Sex: M F
Last Name First Name Middle Initial
Date of Birth_____________________________ School Name ____

5.Name of Child____ Sex: M F
Last Name First Name Middle Initial
Date of Birth_____________________________ School Name ____

Home Address____
Street City State Zip
Whom May We Thank For Referring You ____

Person Financially Responsible ______________________ Cell # (___)_____________ Work # (___)____________

Father/Guardian's Name_________________________
Address (if different from patient)____________________
____
Cell # (___)____________Work #(___)_______________
Email: ____
Soc. Sec. #_________________Birthday______________
Do you have dental insurance coverage? _____________
Plan Name__________________ Phone(___)_________
Address_______________________________________
Group # ________________ Policy #________________
Employer______________________________________

Mother/Guardian's Name_________________________
Address (if different from patient)____________________
____
Cell # (___)____________Work #(___)_______________
Email: ____
Soc. Sec. #_________________Birthday______________
Do you have dental insurance coverage? _____________
Plan Name__________________ Phone(___)_________
Address_______________________________________
Group # ________________ Policy #________________
Employer______________________________________

Emergency Contact

In the event of an emergency who should we contact?

Name ______________________________________ Relationship______________________________
Phone (___)____________________________________

Release of Consent for Treatment

Patient's Names ____

____

People who may bring my children to dental appointments are: __________________________________

____

(This includes operative appointments and allows this person to sign for treatment to be done at the operative visit, sign for any changes that may occur with treatment at the visit and receive post-operative instructions for care of my child after the visit.)

People who may sign or consent to a proposed treatment plan are: ______________________________

____

People who may receive a copy of my children's records including radiographs are: ______________________

____

Please provide contact information for these people: ____

____

I understand that Pediatric Dentistry of Keller will be unable to release ANY information to anyone other than the person/ persons listed above. I understand my children MAY NOT BE SEEN FOR TREATMENT if the person bringing my children is not listed above.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosure given to the person/persons listed above prior to revocation of consent will be permissible.

Parent/Guardian Printed Name: -____

Parent/Guardian Signature: ____ Date: ____________________

Photography Release/Consent

Here at Pediatric Dentistry of Keller, we make every effort possible to make our patients feel special. We love to share pictures of our patients' beautiful smiles on our Facebook page, Instagram page, website and other office related materials for our friends and family to see just how much fun a visit to the dentist can be! Please check one of the following boxes and sign below.

☐ **I AGREE** and hereby grant full permission to Pediatric Dentistry of Keller, Dr. Jacob Johnson and staff to use either myself or my children's names and photographs in any publication or advertising materials (printed or electronic), and social media. This consent serves to waive all rights of privacy or compensation which I may have in connection with the use of my photograph and/or my child's photograph or name.

☐ **I DO NOT AGREE** to have mine or my children's names or photographs used for public viewing.

Patient's Names ____

____

Parent/Legal Guardian's Name (Print) ____

Relationship to Child ____

Signature ____ Date ___________________________

Financial Agreement

Please read and initial each of the following:

______ **Payment:** Payment is expected in full for each appointment as services are rendered. Payment options are:
Cash
Check (There is a minimum fee of $32 for every check returned by the bank)
Credit Card (MasterCard, Visa, and Discover)

______ **Dental Insurance:** We do participate and accept most PPO plans and Medicaid; however, it is your responsibility to confirm with your insurance company that the doctor is under contract with your specific plan. Any deductible, co-pay, non-covered services, and any other charges your insurance does not cover will be your responsibility and paid in full at the time of service.

______ **Missed Appointment:** Our office courteously requests 24 hours notification if you are unable to keep your scheduled appointment so that we can make arrangements for someone else to fill that time. There will be a $50 fee for broken or missed appointments. Patients with multiple missed appointments may be asked to transfer their records to another doctor.

______ **Emergency/After Hours Appointment:** If your child has not been previously seen by our office all emergency treatment must be paid in full at the time of service.

_______ **Finance Charge:** A finance charge will be added to your account for any balance that is unpaid within (60) days of the date of service. The FINANCE CHARGE will be computed at the rate of (10%) per month.

_______ **Past Due Accounts: I**f your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are incurred.

_______ **Divorce/Separation:** In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

_______ **Effective Date:** Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

This is an agreement between Pediatric Dentistry of Keller and the Patient/Debtor named on this form. In this agreement the words "you," your" and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name for your child to which charges are made and payments are credited. The words "we," "us," and "our" refer to Pediatric Dentistry of Keller.

____
Patient's Names

____
Parent/Legal Guardian/Responsible Party (Printed)

____________________________________ ____________________
Parent/Legal Guardian/Responsible Party (Signature) Date

Acknowledgement of Notice of Privacy

I have received a copy of the office's Notice of Privacy Practices.

Your Name (Please Print): ____

Your Signature: ______________________________________ Date: ________________________

List all your children seen by our practice: ____

____

Please list any other person(s) that we may discuss treatment, recommendations and/or billing issues: __________

____

Electronic Communication

______ I do agree

______ I do not agree

That Pediatric Dentistry of Keller may communicate with me electronically at the email address and phone number listed below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing any updates to my email address and/or phone number.

Preferred email: ____

Preferred phone number for text messaging:___________________________________

Pediatric Dentistry of Keller does not share the names, email addresses and/or telephone numbers of patients with any other patient or company.

Sign:____ Date:________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) ____

Received by: ____ Date: ____________________