# Welcome!

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your child's dental needs.

## Patient and Family Information

Child's Name _____ Birthdate _____ ☐Male ☐Female

Social Security # _____ Home Phone _____

Home Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Responsible Party _____

Relationship to Child _____

Name of Mother/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Name of Father/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

## Child's Dental History

Former Dentist _____ Office Phone _____

Address _____

City _____ State _____ Zip _____

Date of last dental visit _____

How often does your child brush? _____

How often does your child floss? _____

Please check all that apply to your child:

☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth

☐ Lip or Cheek Biting ☐ Jaw Difficulty: Clicking and/or Pain

## Child's Health History

Please check all that apply to your child:

☐ Allergies ☐ Diabetes ☐ Hepatitis – Type _____ ☐ Tuberculosis

☐ Anemia ☐ Epilepsy ☐ Rheumatic Fever ☐ Other _____

☐ Asthma ☐ HIV/AIDS ☐ Scarlet Fever _____

☐ Cancer ☐ Heart Murmur ☐ Tonsillitis _____

## Primary Dental Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

## Additional Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

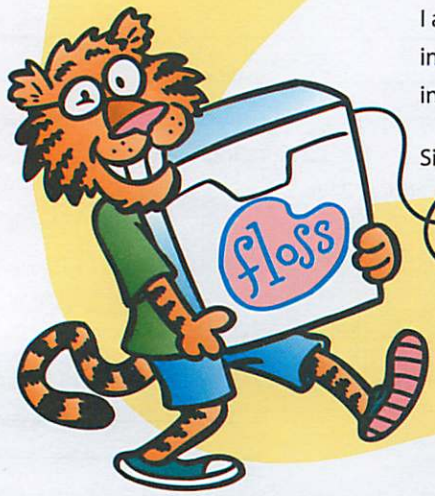
Subscriber I.D. # _____ Group # _____

## Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____


# Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

**Uses and Disclosure**

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health is never sold, rented, transferred, exchanged and/or used for non-healthcare related purposes including marketing activities without your written consent.
- Your protected health information is disclosed to third party entities without your written authorization for the purpose of treatment, to obtain payment for each treatment, and for healthcare operations.

**Certain Circumstances**

Your protected health information can be disclosed without your written authorization in certain limited circumstances:

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization to disclosed protected health information, you can revoke that authorization in writing at any time.

**Patient Rights**

- You have the right to request in writing to inspect and/or receive a copy of your health information.
- You have the right to request an alternate means or location to receive communications regarding your health information.
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.
- You have the right to request in writing an accounting of certain disclosures of your health information that were made in this office.

**Conditions and limitations may apply; obtain additional information from front desk*

**Changes to this notice: We reserve the right to change privacy practice and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be made available to you.**

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

I _____ (Patient), Acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Patient's Signature Date

If the patient is a minor, a parent or legal guardian must sign.

_____

Parent or Legal Guardian Date Relationship to Patient

# Andy B. Kehmeier, D.D.S.

## Financial Arrangements

There are several methods of payment available. In order that we may have a definite understanding regarding the payment of dental fees, please choose one of the following:

_____**A. PAYMENT AT THE TIME OF SERVICE**: Payment for dental services may be paid for at each appointment by, cash, check, or credit card. All new patients must pay for services as they are performed. A 5% discount is given for payment in full, at time of service, for cash or checks

_____B. **CARE CREDIT**: We can help arrange a health care credit card. After a patient's credit is approved Care Credit offers several options for financing. No initial payment is required.

_____C. **INSURANCE COVERAGE**: For your convenience we will bill your insurance company, however, any existing balance after insurance pays will be subject to 15% interest after 90 day and the balance is due at the following billing cycle. For extended treatment plans, crowns, bridges, prosthodontics and endodontics a pre-authorization will be sent to your insurance company.

_____D. **MEDICAID/HEALTHY MONTANA KIDS**: Anything Medicaid/HMK does not cover, you are responsible for. By signing this form I acknowledge current coverage with Medicaid or HMK.

I understand the financial arrangements above and agree to comply with them. I agree that parents are responsible for all fees and services rendered for treatment of a child. I understand that I am responsible for ALL fees regardless of insurance coverage. In the event that my payments are not received within 30 days of their due date, I agree to pay all cost of collections, including, but not limited to, reasonable attorney's fees.

Patient
Name:_____

Responsible Party: _____
(Printed)

Responsible
Party:_____
(Signature) (Date)