Welcome!

Patient Information

Date	**SS/HIC/Patient ID#**		**Birthdate**
Name of Minor/Child			
	Last Name	First Name	Middle Initial
Sex ☐ M ☐ F	**Nickname**	**Hobbies**	**Phone** ( )
Home Address			
	Street	City	State/Zip
Mailing Address			
	Street	City	State/Zip
School Name			**School Phone** ( )
Person financially responsible		**Home** ( )	**Work** ( )
Whom may we thank for referring you?			

Insurance

Father's/Guardian's Name		**Mother's/Guardian's Name**	
Address (if different from patient's)		**Address** (if different from patient's)	
Home ( )	**Work** ( )	**Home** ( )	**Work** ( )
Email		**Email**	
Employer		**Employer**	
Soc. Sec. #	**Birthdate**	**Soc. Sec. #**	**Birthdate**
Do you have dental insurance coverage for minor/child?	☐ Yes ☐ No	**Do you have dental insurance coverage for minor/child?**	☐ Yes ☐ No
Plan Name	**Phone** ( )	**Plan Name**	**Phone** ( )
Address		**Address**	
Group #	**Policy #**	**Group #**	**Policy #**
Is your child eligible for treatment under Medical Assistance?	☐ Yes ☐ No	**Child's Medical Assistance I.D. #**	

Dental History

Date of last visit to a dentist		**For what service?**	
Has child complained of dental problems?	☐ Yes ☐ No	**Is fluoride taken in any form?**	☐ Yes ☐ No
Does child brush teeth daily?	☐ Yes ☐ No	**Any injuries to mouth, teeth, head?**	☐ Yes ☐ No
Does child use floss daily?	☐ Yes ☐ No	**Any unhappy dental experiences?**	☐ Yes ☐ No
Any mouth habits: thumb-sucking, mouth-breathing, pacifier, sleeping w/bottle?	☐ Yes ☐ No		



Medical History

Minor's/Child's Physician		**City/State**	**Phone** ( )
Date of last physical examination		**Results**	
Medications		**Allergies**	
Is Minor/Child under care of physician now?	☐ Yes ☐ No	**Receiving any medication or drugs?**	☐ Yes ☐ No
Ever been hospitalized?	☐ Yes ☐ No	**Ever had surgery?**	☐ Yes ☐ No
Is there excessive bleeding when cut?	☐ Yes ☐ No		

Has minor/child ever had any history and/or difficulty with any of the following? If yes, please check the box.	☐ A.I.D.S./H.I.V.	☐ Bladder Problems	☐ Chicken Pox
	☐ Anemia	☐ Cancer	☐ Convulsions
	☐ Asthma	☐ Cerebral Palsy	☐ Diabetes
☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Kidney Disease	☐ Mononucleosis
☐ Epilepsy	☐ Heart Problems	☐ Liver Disease	☐ Mumps
☐ Fainting	☐ Hearing Problems	☐ Measles	☐ Rheumatic Fever
☐ Sinus Problems	☐ Other		
☐ Thyroid Disease			
☐ Tuberculosis			

Emergency Contact

In the event of an emergency, whom should we contact?

Contact #1	**Name:**	**Relationship:**	**Phone** ( )
Contact #2	**Name:**	**Relationship:**	**Phone** ( )

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to let my doctor know if my minor/child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

Please print name of minor/child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is/are covered by insurance with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits/benefits payable for related services.

Parent, Guardian, or Personal Representative Signature _____ Date _____

Print Parent, Guardian, or Personal Representative Name _____ Relationship _____

COMPLETE DENTISTRY

Calvin Kenley, DMD

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT

Patient Name: _____ Date of Birth:_____

I have received this practice's Notice of Privacy written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

The Notice includes:

- A statement that, this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice in not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of it's Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice’s current Notice of Privacy Practices on request.

Signature:_____ Date:_____

Relationship to patient (if signed by a personal representative of patient):_____

COMPLETE DENTISTRY

Calvin Kenley, DMD

AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

Patient Name:_____

Address:_____

Date of Birth:_____ Date of Request:_____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

_____

Patient Health Information authorized to be disclosed:

_____

_____

For the specific purpose of (describe in detail):

_____

_____

Effective dates for this authorization: ___/___/___ through ___/___/___
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected Patient Health Information.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____ _____

Authorized Signature of Facility Date

COMPLETE DENTISTRY

Calvin Kenley, DMD

FINANCIAL POLICY

Dear Patient/Parent,

Welcome and thank you for choosing Complete Dentistry as your dental health care provider. We ask that all patients read and sign our Financial Policy prior to being seated.

1. Payment for services is due in full at the time services are rendered. For your convenience we accept cash, personal checks, Visa, Master Card, Discover, and Care Credit.

2. Dental insurance: if you are covered by dental insurance please be sure that you have provided us with accurate information. We accept most of the major dental insurance carriers and will process your claim as quickly as possible.

As you know, not all insurances are the same so we ask you to read your policy very carefully. We have found that benefit coverage has taken a drastic change over the past few years requiring the patient to assume more of the cost for their care. It is important that patients realize that they will be responsible for any remaining account balance.

3. Secondary insurance claims: we do not process secondary or medical insurance claims. We will provide a fully coded receipt to attach to your claim for your convenience.

4. We do not intercede with separated or divorced parents for payment. The parent who brings the child to the office is expected to pay at the time services are rendered. Financial responsibility for care of a minor child outlined in legal agreements is independent of office policy.

5. An appointment is a reservation of time set aside for your care. If you are not able, to keep your appointment please let us know as soon as possible so that we may be able to accommodate someone else.

In summary, the patient is responsible for any unpaid balance on their account.

Patient or Guarantor Signature_____ Date_____