Matthew L. Keller, DMD
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We are so pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to assist you. We look forward to working with you in maintaining your child's dental health!

PATIENT INFORMATION

Child's Name: _____
LAST FIRST MIDDLE PREFFERED

☐ Male ☐ Female Date of Birth: ___/_____/_____ Social Security # _____

Hobbies: _____

Address: _____
STREET APT# CITY STATE ZIP

Home Phone#: _____ Mom's Cell#: _____ Dad's Cell#: _____

Email Address: _____

How would you prefer us to contact you regarding notice of upcoming appointments?

☐ Text ☐ Cell ☐ Home Phone

Whom may we thank for referring you to our practice? _____

PARENT'S INFORMATION

☐ Mother ☐ Stepmother ☐ Guardian Name: _____

Address: (if different from above): _____

Home # (if different from above): _____ Work # _____ ext ____ Employer: _____

Social Security # _____ DOB _____

☐ Father ☐ Stepfather ☐ Guardian Name: _____

Address: (if different from above): _____

Home # (if different from above): _____ Work # _____ ext ____ Employer: _____

Social Security # _____ DOB _____

PRIMARY INSURANCE INFORMATION

Policy Holder:_____ Relationship to patient:_____

Policy Holder's Social Security#: _____ Date of Birth:_____/_____/____

Insurance Company:_____ Employer: _____

Policy #_____ Group#_____ Telephone # of Ins Company_____

SECONDARY INSURANCE INFORMATION

Policy Holder:_____ Relationship to patient:_____

Policy Holder's Social Security#: _____ Date of Birth:_____/_____/____

Insurance Company:_____ Employer: _____

Policy #_____ Group#_____ Telephone # of Ins Company_____

DENTAL HISTORY

Last dental visit: _____/_____/_____ *Last Cleaning:*_____/_____/_____ *Last* X-rays:_____/_____/_____

Previous Dentist:_____ Do you have a copy of previous X-rays? ❑ Yes ❑ No

My child brushes his/her teeth ____times a day.

Do you ever help your child brush his/her teeth? ❑ Always ❑ Sometimes ❑ Never

Does your child floss every day? ❑ Yes ❑ No

Is there a history of bad dental experiences? ❑ Yes ❑ No

Please explain_____

Do you expect your child to be cooperative? ❑ Yes ❑ No

Is your child in pain today? ❑ Yes ❑ No

Please explain_____

Is fluoride taken in any form? ❑ Yes ❑ No

Any injuries to mouth/teeth? ❑ Yes ❑ No

Are you on well water? ❑ Yes ❑ No

Does your child do well at hair appts.? ❑ Yes ❑ No

Does your child have any mouth habits? (Please circle all that apply)

Thumb/Finger Sucking Grinding during sleep Pacifier Sleeping with bottle Other_____

Does your child have a dental condition about which you are especially concerned? _____

_____

MEDICAL HISTORY

Child's Name: _____

Child's Pediatrician: _____ City/State: _____ Phone: _____

Date of last physical exam: ____/____/____

Has he/she ever been hospitalized or had surgery? ❑ Yes ❑ No If so, why?: _____

Any handicaps/disabilities? ❑ Yes ❑ No Please List: _____

Place a mark on "yes" or "no" if your child has had any of the following:

ADD/ADHD	❑ Yes ❑ No	Drug/Alcohol Abuse	❑ Yes ❑ No	Radiation/Chemotherapy	❑ Yes ❑ No
AIDS/HIV	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Reflux	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Autism	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Sickle Cell	❑ Yes ❑ No
Bladder Issues	❑ Yes ❑ No	Heart Valve Replacement	❑ Yes ❑ No	Sinus Problems	❑ Yes ❑ No
Bleeding Issues	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Skin Disorder	❑ Yes ❑ No
Cancer/Tumors	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No	Speech Problem	❑ Yes ❑ No
Cerebral Palsy	❑ Yes ❑ No	Kidney/Stomach Disease	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Cleft Palate	❑ Yes ❑ No	Learning Disabilities	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Hearing Loss	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No	Other: _____	
Chicken Pox	❑ Yes ❑ No	Measles	❑ Yes ❑ No	_____	
Diabetes	❑ Yes ❑ No	Mumps	❑ Yes ❑ No	_____	

Girls: Are you pregnant? ❑ Yes ❑ No Are you on well water? ❑ Yes ❑ No

If you said yes for the following:

Asthma when was your child's last attack?_____ Has he/she ever been hospitalized for asthma?_____ If so when?_____

Epilepsy when was your child's last seizure?_____ Has he/she ever been hospitalized for epilepsy?_____ If so when?_____

Any additional health concerns?_____

_____

MEDICATIONS

Please list any medications that your child is currently taking and the correlating diagnosis: _____

_____

ALLERGIES

❑ None ❑ Penicillin/Amoxicillin ❑ Latex ❑ Aspirin ❑ Sulfa ❑ Local Anesthetic

❑ Metal ❑ Other (Please list):_____

Update:_____ _____
signature date

Update:_____ _____
signature date

Update:_____ _____
signature date

Update:_____ _____
signature date

Update:_____ _____
signature date

Columbus Children's Dentistry, PC

You may refuse to sign this acknowledgment

I have read and been offered a copy of this office's Notice of Privacy Practices and Office Policies.

Print Name: _____

Signature: _____

Date: _____

For office use only

_____

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

_____

_____

_____

Thank you for allowing Columbus Children's Dentistry to partner with your family in an important aspect of your child's growth and development! Dr. Keller maintains board certification in Pediatric Dentistry in order to stay up-to-date with current practices and innovations in the specialized field of pediatrics and to provide cutting edge technology and oral health information. To optimally impact your child's oral health, it is important to be consistent with regular (at least every 6 month) cleaning visits and to follow-up with treatment recommendations provided by Dr. Keller and his knowledgeable staff. While "no-shows" and "late cancellations" are at times unavoidable, they often present issues with future scheduling, treatment delay(s), and/or delayed diagnosis of critical issues. Furthermore, these absences *can* interfere with availability of other patients who could attend these scheduled appointments. Our attendance policies ensure that each patient has an appropriate amount of time, staff, and supplies for your reserved appointment time. Please carefully review the following policies and notify our office if you have any questions or concerns.

CONFIRMATIONS:

_____ Columbus Children's Dentistry utilizes scheduling software to automatically notify of schedule appointment times. This software will attempt to confirm appointments multiple times prior to the scheduled appointment. Our office staff will then attempt to confirm all appointments that remain unconfirmed at least 2 days prior to the actual appointment time.

_____ **Unconfirmed appointments will be removed from our schedule at noon one day prior to the appointment time.**
Please ensure that our Front Office has accurate contact information (mobile number and email) to receive these automated messages. Also, please notify our Front Office if you are not receiving automated communication messages prior to appointment times.

CANCELLATIONS:

_____ Appointments must be cancelled at least 24 business hours in advance by calling our office or responding to a text or email confirmation request.

- **Cancelled appointments will not be automatically rescheduled.**
- **Cancellations left on the office voicemail will be cancelled when the office re-opens.** (eg. Cancellation request left on voicemail on Friday night for a Monday morning appointment will not be cancelled until Monday morning- therefore counts as a BROKEN appointment.)
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BROKEN APPOINTMENTS/NO SHOWS:

_____ A broken appointment is defined as a cancelled appointment within 24 business hours of the appointment time. A "No-Show" is defined as failure to present for a confirmed appointment. Patients with ***3 broken and/or no-show HYGIENE appointments within a rolling eighteen-month period*** WILL NOT be allowed to schedule further appointments.

_____ A broken or no-show appointment for ***TREATMENT*** can be rescheduled with a $50 deposit that will be credited toward pending treatment costs. If the patient does not present for that rescheduled appointment, this $50 fee will be forfeited.

FINANCIAL COSIDERATIONS:

_____ Patients must provide active insurance information for insurance claims to be processed in a timely manner. Whenever possible, we ask that insurance information be provided (or updated) at least 48 hours prior to your child's appointment time in ensure adequate time for verification. If insurance is unable to be verified prior to the appointment time, the parent/guardian may be responsible for the full amount of charges incurred.

_____ Estimates for patient responsibility are provided with all treatment plans. THESE ARE ONLY ESTIMATES. All appeals and/or disputes should be handled with your insurance company.

LATENESS:

_____ Patients who arrived more that ten minutes after their scheduled appointment time will be asked to reschedule to ensure maximum benefit and quality care for dental cleanings and schedule treatment appointments. Our staff will make a reasonable effort to accommodate scheduling needs without significant delay.

TREATMENT:

_____ For the safety of your child and our staff, we ask for ONLY ONE PARENT/GUARDIAN to accompany their child in treatment areas. The accompanying parent/guardian is welcome to remain in the treatment room in the designated seating area (i.e.- please do not sit on the dental chair). Siblings and/or other family members must remain in waiting areas.

OR TREATMENT/IN-OFFICE SEDATION:

_____ Columbus Children's Dentistry offers dentistry under sedation in a variety of settings. Dr. Keller maintains privileges at Piedmont Columbus Regional Medical Center, as well as, provides in-office sedation (in conjunction with Pediatric Dental Anesthesia Associates) to accommodate younger or special needs patients with extensive dental care needs and/or high anxiety with dental procedures. Our office will coordinate with your insurance company (if needed) and the hospital to schedule your child for treatment in the operating room (OR) if recommended by Dr. Keller. As this process is fairly involved and appointments are limited, ***we require payment in full for all services at the time of scheduling*** to reserve your treatment time. Procedures will be sent for processing on the actual date of services.

_____ Appointments for OR/in-office sedation must be cancelled at least 2 weeks prior to the scheduled date to receive a full refund for treatment (or full amount can be applied to rescheduled treatment balance). Appointments cancelled within 1 week of OR treatment may forfeit up to 50% of treatment balance.

_____ Treatment plans older than 6 months must be re-evaluated by Dr. Keller prior to scheduling treatment.

UNEXPECTED CLOSURES:

_____ If Columbus Children's Dentistry closes unexpectedly (due to inclement weather, power outages, or health concerns), our office staff will notify all scheduled patients as soon as possible. Affected appointments will be rescheduled when possible. Our office does not necessarily close if schools are closed. Please call our office with questions.

My signature below indicates that I have read the above policies and that I understand and accept these terms and conditions.

_____ _____

Signature of Parent/Guardian **Print Name of Parent/Guardian**

_____ _____

Print Name of Patient(s) **Date**