



Michael A. Keller, DDS, PC

Pediatric / Adolescent Dentistry
2045 Medical Center Drive
Birmingham, AL 35209
(205) 870-7110

Today's Date _____

Child's Name _____

Sex M F (circle)

Age _____ Date of Birth _____ School _____

Mother's Name _____ Date of Birth _____ SS# _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employed By _____

Father's Name _____ Date of Birth _____ SS# _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employed By _____

E-Mail address _____

Child resides with: Both Parents Mother Father Other

Parent's Marital Status: Married Divorced Single Widowed

Name of Primary Dental Insurance _____ Contract# _____ Group# _____

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

Person to be contacted in case of emergency other than parent(s):

Name _____ Relationship _____ Phone number _____

APPOINTMENT & CANCELLATION POLICY: In the event you must accompany your child into the treatment area, you must make the appointment before 2:00pm.

We require a 24 hour notice if you cannot bring your child to their scheduled appointment. There is a charge if appointments are broken without adequate notice.

PAYMENT POLICY: Payment is due at the time of service. An itemized statement marked paid and/or an insurance form will be provided for you at the time of your visit to ensure prompt reimbursement.

I accept full responsibility for this account and for all charges incurred for dentistry performed upon my dependents in this dental office. I understand that it is up to me to confirm my child's eligibility, waiting periods, and benefits and that this office cannot guarantee my child's status in any of these areas. Any insurance estimate given to me by this office is not a guarantee of actual coverage.

Any returned checks will be assessed a \$35.00 charge.

We thank you for your cooperation and look forward to providing the highest quality dental care for your child with a clear understanding of each party's responsibilities.

I have read and fully understand the above **APPOINTMENT, CANCELLATION AND PAYMENT POLICIES** and accept all provisions.

NAME _____ **DATE** _____

RELATIONSHIP TO PATIENT _____

PERMISSION TO TREAT: Since your child is a minor it becomes necessary that signed permission be obtained from the parent or guardian for any and/or all necessary dental services.

I hereby authorize Dr. Michael A. Keller, and the dental auxiliaries under direct supervision of the dentist, to perform any necessary dental treatment upon my child, including but not limited to the use of anesthetic, radiographs, and/or nitrous oxide (laughing gas).

We look forward to caring for your child's dental needs in the most comfortable manner possible.

SIGNATURE OF PARENT OR GUARDIAN _____

MEDICAL AND DENTAL HISTORY

Child's Name _____ Preferred Name _____ Date of Birth _____

Child's Physician _____ Phone _____

Date of last medical exam _____

Is your child in good health? Yes No Explain _____
 Is your child under the care of a physician? Yes No Explain _____
 Has your child had surgery/hospitalizations? Yes No Explain _____
 Are immunizations up to date? Yes No Explain _____
 Is your child taking any medications? Yes No Explain _____
 Is your child allergic to anything? Yes No Explain _____
 Has your child had a reaction to penicillin or any other drug? Yes No Explain _____
 Do you have fluoride in your water system? Yes No Source of drinking water _____
 (city, well, bottled)

Does your child have any of the following?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> TMJ | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sickle Cell Trait |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Syndrome _____ |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Premature Birth | <input type="checkbox"/> Eye Problems | _____ |
| <input type="checkbox"/> Developmental | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Behavioral Problem |
| <input type="checkbox"/> Disorder | <input type="checkbox"/> Endocrine Disorder | <input type="checkbox"/> Visual Problems | <input type="checkbox"/> Learning Disorder |
| <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Speech Disorder | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Retardation | <input type="checkbox"/> Date _____ |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Cancer/Tumor | Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | |

If yes to any of the above, please explain _____

Is today your child's first dental visit? Yes No

Name of previous dentist _____ Date of visit/x-rays _____

Has your child had an unfavorable dental experience? Yes No Explain _____

How often does child brush teeth? _____ Floss _____ Does someone help? _____

Has child ever had injury to face/teeth? Yes No Explain _____

Are there any mouth habits: finger, pacifier, tongue thrust, grinding, mouth breather, other? _____

What age was bottle/breast feeding discontinued? _____

Does your child eat frequent between meal snacks? Yes No Drink soda/juice between meals? Yes No

Do you expect your child to cooperate during the dental visit? Yes No

How many other children in child's family do we see? _____ What are their names? _____

THANK YOU FOR YOUR HELP. IF THERE IS ANY INFORMATION THAT YOU FEEL MIGHT BE VALUABLE TO US IN TREATING YOUR CHILD, PLEASE LET US KNOW. _____

