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	
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?

___Asthma	___Latex Allergy	___Mental Disorder	___Heart Murmur
___Cleft Lip/Palate	___Spina Bifida	___TMJ	___Cerebral Palsy
___Kidney Disease	___Birth Defects	___Nervous Disorder	___Sickle Cell Disease
___Sleep Apnea	___Emotional Disorder	___Tuberculosis	___Sickle Cell Trait
___Snoring	___Liver Disease	___Heart Disease	___Syndrome_________
___Autism	___Premature Birth	___Eye Problems	____________________
___Developmental Disorder	___Blood Disease	___Heart Problem	___Behavioral Problem
	___Endocrine Disorder	___Visual Problems	___Learning Disorder
___Lactose Intolerance	___Lung Problems	___Rheumatic Fever	___Blood Transfusion
___Speech Disorder	___Thyroid Disorder	___Retardation	Date______________
___AIDS/HIV	___Brain Injury	___Cancer/Tumor	Other _______________
___Diabetes	___Epilespy	___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. ____

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MICHAEL A. KELLER, D.D.S., P.C.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR MARKETING PURPOSES:

PURPOSE OF AUTHORIZATION: By signing this form, you will give our office authorization to use your child's/children's protected health information, (specifically if your child/children have no cavities upon their routine preventive visits) for our marketing purposes described below.

AREAS OF MARKETING: By signing this authorization the parent gives permission for their child/children to sign their name to our in-office "NO SUGAR BUG CLUB" bulletin board when they have received a " no cavity" check-up on routine visits. Also by signing this authorization the parent allows our office to use their child's/children's name in the monthly publication of the Over the Mountain Journal specifically for the "NO SUGAR BUG CLUB" and ,if appropriate, for the purpose of our monthly in-office marketing games and contest. Also by signing this the parent is authorizing their child's/children's picture to be used for occasionally advertising and marketing.

RIGHT TO REVOKE: You have the right to revoke the Authorization at any time by giving us written notice of your revocation submitted to the contact person listed below. Please understand that based on the time of the month that the revocation is given we may or may not be able to cancel your child's/children's name or picture in any up-coming publication. However, all efforts will be made to fulfill your requests. Please also understand that revocation will have no bearing on the treatment and care of your child/children in our office.

SIGNATURE: I, ____

Give authorization for my child/children :____

To participate in all the marketing activities described in this form for twenty-four (24) months from this date:____

Contact Person: Melinda Sullivan for the office of Dr. Michael Keller
Telephone: (205) 870-7110
Address: 2045 Medical Center Drive Birmingham, Al. 35209

HIPAA PRIVACY FORM 1

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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Michael A. Keller, D.D.S., P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD/CHILDREN MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR CHILD/CHILDREN'S HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your child/children's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's/children's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about your child's/children's for treatment payment and healthcare operations. For example:

Treatment: We may use or disclose your child's/children's health information to a physician or other healthcare provider providing treatment to your child/children .

Payment: We may use and disclose your child's/children's information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your child's/children's health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your child's/children's health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's/children's health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your child's/children's health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your child's/children's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's/children's health information to a family member, friend or other person to the extent necessary to help with your child's/children's healthcare or with payment for your child's/children's healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your child's/children's care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your child's/children's health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant

to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's/children's best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your child's/children's health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your child's/children's health information when we are required to do so by law.

Abuse or Neglect: We may disclose your child's/children's health information to appropriate authorities if we reasonably believe they are possible victims of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's/children's health information to the extent necessary to avert a serious threat to your child's/children's health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your child's/children's health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your child's/children's health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your chilld's/children's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your child's/children's health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your child's/children's health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your child's/children's privacy rights, or you disagree with a decision we made about access to your child's/children's health information or in response to a request you made to amend or restrict the use or disclosure of your child's/children's health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your child's/children's health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Melinda Sullivan

Telephone: (205) 870-7110 Fax: (205) 871-3339

Address: 2045 Medical Center Drive Birmingham, AL. 35209

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HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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Michael A. Keller, D.D.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Child's/Children's Name}

____
{Signature}

____
{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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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