Gentle Dental Care for the Family

OFFICE PHILOSOPHY

We strive for excellence in every aspect of your dental care, and we will always do our best to serve our dental patient's needs, in an honest & timely manner.

We respect your appointed time, and make every effort to stay on schedule ourselves. Since we rarely are late, please understand if we are delayed because of a dental emergency.

If you have an emergency dental problem, we will make every effort to see you as soon as possible.

FINANCIAL POLICY

Payment is due on the day services are rendered unless prior financial arrangements have been made. Any discount or coupons are void unless payment is made on the day of service.

Your dental insurance claims will be submitted as a courtesy, however you must pay your portion of the bill on the day of service. If you do not pay your portion on the day of service, a service charge of 2% (24% APR), with a monthly minimum fee of $15.00 for outstanding balances may be charged. If insurance reimbursement is not received, you are responsible for the balance. A credit check may be run on each patient.

Sound financial arrangements & office policy enable us to deliver needed dental care to all of our patients and helps us to keep our fees stable while providing quality dental care without compromise.

APPOINTMENT POLICY

48 hours notice is Required to reschedule or cancel your appointment.

Your appointment time is reserved for you, and we need sufficient time to schedule other patients who are waiting to be seen. Patients may be billed a fee for missing an appointment without sufficient advance notice ($75.00 per hour). Patients who miss two appointments without sufficient notice may be dismissed as patients of this office.

10552 W. Garverdale Ct., #904 · Boise ID 83704 · 208.323.2010 · Fax 208.323.1270 · www.vkdds.com

PATIENT REGISTRATION

PLEASE COMPLETE FRONT & BACK

PLEASE PRINT TODAY'S DATE ______________________________

PATIENT INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU? ________________________________

Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

NAME ____ MALE ☐ FEMALE ☐
FIRST MI LAST

MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ DATE OF BIRTH ______________________________

I PREFER TO BE CALLED BY ________________________________ ________________________________
Social Security Number

ADDRESS ____
STREET CITY STATE/ZIP

HOME PHONE ______________________ MAY WE LEAVE MESSAGE? YES ☐ NO ☐ WORK PHONE ________________ MAY WE LEAVE MESSAGE? YES ☐ NO ☐

CELL PHONE ______________________ FAX __________________________ E-MAIL ______________________________

MAY WE CONTACT YOU BY E-MAIL WITH ACCOUNT/PERSONAL INFORMATION? YES ☐ NO ☐

OCCUPATION ______________________________ EMPLOYER 'S NAME____

WORK ADDRESS ____
STREET STATE/ZIP CITY

FINANCIAL INFORMATION

WHO IS FINANCIALY RESPONSIBLE FOR THIS ACCOUNT? (An individual, not your insurance) SELF ☐ OTHER ☐ ______________
RELATIONSHIP

NAME ____ DATE OF BIRTH ______________________________

SAME ADDRESS? YES ☐ IF NO, ____
STREET CITY STATE/ZIP

________________________________ __________ ______________________________________
DRIVER'S LICENSE NO. STATE SOCIAL SECURITY NUMBER

OCCUPATION ______________________________ EMPLOYER'S NAME ____

WORK ADDRESS ____
STREET CITY STATE/ZIP

HOME PHONE ______________________ WORK PHONE ______________________ CELL PHONE ____________________

EMERGENCY CONTACT

(outside of immediate family)

NAME ____ RELATIONSHIP TO PATIENT ______________________________

ADDRESS ____
STREET CITY STATE/ZIP

HOME PHONE ______________________________________ WORK PHONE ______________________________________

CELL PHONE ______________________________________ E-MAIL ____

Rev. 8-9-07

INSURANCE INFORMATION

PRIMARY CARRIER

PATIENT'S RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ _______________

INSURANCE COMPANY ____ GROUP NO. ____

ADDRESS ____
STREET CITY STATE/ZIP

EMPLOYER NAME ____

INSURED'S NAME SELF ☐ OTHER ☐ ____
NAME RELATIONSHIP

INSURED'S I.D. NUMBER ___________________________________ INSURED'S SOCIAL SECURITY NO. ______________________________

SECONDARY CARRIER

INSURANCE COMPANY ____ GROUP NO. ____

ADDRESS ____
STREET CITY STATE/ZIP

EMPLOYER NAME ____

INSURED'S NAME SELF ☐ SPOUSE ☐ OTHER ☐ ____
NAME RELATIONSHIP

INSURED'S I.D. NUMBER ___________________________________ INSURED'S SOCIAL SECURITY NO. ______________________________

Conditions of Treatment

As a condition of your treatment by this office, all payments are due when services are rendered. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms and assist the patient in making collections from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. If you do not pay your portion on the day of service, there will be a billing service charge of 2% per month (24% APR) with a minimum charge of $15 per month for any outstanding balance.

Consent for Services

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, unless other arrangements have been made. If required, I also understand a check of my credit history may be made. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. I understand that any discounts are void if my balance (patient's portion) is not paid on the day of service.

I understand that the treatment plan and fees are an estimate only, and changes may occur during the course of treatment. I understand that the dentist will make every effort to inform the patient or responsible party before treatment is rendered when possible. I understand that fees may change at any time. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operation. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information will be given to me.

I understand that **48 hours notice is required to reschedule or cancel my appointments**, and that a $50 fee may be charged for canceling or missing an appointment without sufficient advance notice. I understand that patients who miss two appointments without sufficient advance notice may be dismissed as patients of this office.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment. I understand that I can ask for a complete recital of any further possible complications.

I have read the above conditions of treatment and consent for services and agree to their content.

____ Date ______________________ Relationship to Patient _________________________
Signature of Patient, Parent or Guardian

____ Date ______________________
Signature of Staff Member

Assignment of Insurance Benefits

In order for us to process your insurance claims, we will need your signature to release payment.

I authorize release of any information relating to any claim for services rendered to me or my dependents.

I assign and request your company to pay directly to Valerie Kellbach, DDS insurance benefits otherwise payable to me or my dependents.

I understand I am financially responsible to Valerie Kellbach, DDS for charges not covered by this assignment. If my indebtedness for such charges is placed with an attorney or collection agency for collection, I agree to pay Valerie Kellbach, DDS such collection cost, including attorney fees.

____

Please Print Patient's Name

____ ____________________________

Authorizing Signature (Parent/ Guardian if the Patient is a Child) Date

____

Relationship of Patient & Authorizing Signer

Valerie Kellbach, DDS

Dental Care for the Family

Your Child's Dental History and Habits

Today's Date ______________________________

Your Child's Name ______________________________ **Date of Birth** ______________________________

Welcome! *So that we may provide your child with the best possible care, please complete both sides of this dental/medical history form. All information is completely confidential. Please be sure to answer individually any yes or no questions.*

What is the reason for your visit today? ______________________________

____

Is this your child's first visit to the dentist? ◻ Yes ◻ No Previous Dentist's Name ______________________________

Address ______________________________Telephone # ______________
Street City State/Zip

Date of your child's last dental visit ______________Last dental cleaning ______________ Last full mouth x-rays ______________

How often does your child brush his teeth? ______________ Floss? ______________ Do you assist? ◻ Yes ◻ No

Is your child's water fluoriated? ◻ Yes ◻ No ◻ Don't Know Does your child take fluoride supplements? ◻ Yes ◻ No

Does your child have any dental problems now? ◻ Yes ◻ No If yes, please describe ______________________________

____

How do you think your child will do? ◻ Good ◻ Fair ◻ Poor

Has your child had difficulty with previous dental visits? ◻ Yes ◻ No If yes, please describe ______________________________

Has your child complained about dental problems? ◻ Yes ◻ No If yes, please describe ______________________________

Has your child ever worn orthodontic applicances? ◻ Yes ◻ No If yes, please describe ______________________________

Are any of your child's teeth sensitive to:

Hot or cold? ◻ Yes ◻ No Sweets? ◻ Yes ◻ No Biting or chewing? ◻ Yes ◻ No

Does your child engage in:

Sucking thumb or fingers? ◻ Yes ◻ No Chewing or biting fingernails? ◻ Yes ◻ No
Biting or sucking lips or cheeks? ◻ Yes ◻ No Chewing hard objects (e.g., pencils?) ◻ Yes ◻ No
Grinding teeth? ◻ Yes ◻ No Clenching jaw? ◻ Yes ◻ No
Mouth breathing/snoring? ◻ Yes ◻ No Nursing bottle or pacifier habits? ◻ Yes ◻ No

Do your child's gums bleed or hurt? ◻ Yes ◻ No

Does your child have any pain or tenderness in the jaw joint, ear, side of face? ◻ Yes ◻ No

Do you have any special concerns about your child's dental health? ◻ Yes ◻ No If yes, please describe ______________

____

Your Child's Medical History

Today's Date ______________________

Your Child's Name ______________________ **Nickname** ______________________

Medical Alert ______________________ **Date of Birth** ______________________

Your Child's Physician ______________________ **Telephone** ______________________

Address ______________________
Street City State/Zip

Is your child under the care of a physician? ☐ Yes ☐ No If yes, please describe ______________________

____

Is your child taking any medications? (prescription or over-the-counter) ☐ Yes ☐ No If yes, please describe ______________________

____

Have you ever been told your child needs antibiotics or premeds before dental treatment? ☐ Yes ☐ No If yes, describe ____________

____

Does your child have any allergic (or adverse) reaction to any medication or other substance? ☐ Yes ☐ No If yes, describe ____________

____

Are your child's immunizations current? ☐ Yes ☐ No

List any Hospitalizations, Surgeries, Serious Illnesses or Injuries? **When?**

______________________ ______________________

______________________ ______________________

______________________ ______________________

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

Condition			Condition			Condition		
AIDS/HIV positive	☐ Yes	☐ No	Congenital heart disease	☐ Yes	☐ No	Lung Problems	☐ Yes	☐ No
Allergies or hives	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles/Mumps	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Nervous disorders	☐ Yes	☐ No
Behavioral Problem	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Psychiatric/Psychological	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Hearing Problems	☐ Yes	☐ No	Rheumatic/Scarlet Fever	☐ Yes	☐ No
Brain Injury	☐ Yes	☐ No	Heart Condition/Murmur	☐ Yes	☐ No	Sickle Cell Anemia	☐ Yes	☐ No
Cancer/Tumor	☐ Yes	☐ No	Hepatitis A B C (circle)	☐ Yes	☐ No	Stomach Problems	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	Kidney/liver problems	☐ Yes	☐ No	Tuberculosis/Positive TB Test	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No	Learning Disability	☐ Yes	☐ No

Other? ☐ Yes ☐ No Please specify ______________________

____

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

______________________ ______________________
Signature of parent or legal guardian Date Dentist's Signature Date

For Completion by Dentist

Comments:

Health History Update:

Date	**Comments**	**Signature of patient and dentist**

Valerie Kellbach, DDS

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practice, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 1, 2004, 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 we maintain, including health information we created or received before we made the changes. Before we make a significant change in our policy 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 you for treatment, payment, and healthcare operations. For example:

Treatment: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your 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 health information for treatment, payment or healthcare operations, you may give us written authorization to use your 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 health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your 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 care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your 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 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 health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your 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 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 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 $0.10 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want 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 of 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 associate disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the past 6 years, but not before November 1, 2004. 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 health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement 9except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your 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 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 privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your 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 may also 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 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: ______________Valerie Kellbach DDS______________________________

Telephone: ______________208-323-2010__________________________ Fax: __208-323-1270______________________________

E-mail: ______info@vkdds.com______________________________

Address: _______10552 W. Garverdale Court, Suite 904, Boise, ID 83704______________________________

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and OFFICE PHILOSOPHY & FINANCIAL POLICY

****You May Refuse to Sign this Acknowledgement****

I, ____, have received a copy of Valerie Kellbach, DDS Notice of Privacy Practices and a copy of the Office Philosophy & Financial Policy.

____
Please Print Name

____
Signature

____
Date

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _______________________________________

Relationship to Patient ____

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)

____

____