



Welcome to Little Smiles

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Diplomate, American Board of Pediatric Dentistry



ABOUT YOUR CHILD:

Name: _____
(FIRST) (M) (LAST)

Nickname _____ Male Female

Date of Birth: _____

Social Security #: _____

Home Address: _____

(Apt #) (City) (State) (Zip)

Email Address: _____

Home Phone: _____

School: _____

Grade: _____

Child's Hobbies, favorite games: _____

Brothers? _____ Age(s): _____

Sisters? _____ Age(s): _____

ABOUT YOUR FAMILY:

Father's Information:

Married Single Guardian Step Father Foster Parent

Name: _____

Social Security #: _____

Date of Birth: _____

Employer: _____ Work Phone: _____

Occupation: _____

Home Phone: _____ Cell Phone: _____

Drivers License#: _____ Exp: _____

Mother's Information:

Married Single Guardian Step Mother Foster Parent

Name: _____

Social Security #: _____

Date of Birth: _____

Employer: _____ Work Phone: _____

Occupation: _____

Home Phone: _____ Cell Phone: _____

Drivers License#: _____ Exp: _____

Who is the primary guardian of your child? _____

DENTAL HISTORY:

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

If no, what was the approximate date of last dental visit? _____ What was the name of the dentist? _____

Was there a previous unfavorable medical/dental experience? Yes No

If so, please explain: _____

Does your child receive fluoride? Yes No If so, which type? Tablets Drops Vitamins Rinse

Is your home supplied with well water or city water?

Does your child brush his or her teeth twice daily? Yes No Do you assist them? Yes No

At what age was bottle or breast feeding stopped? _____

Does your child have any of the following?

Dental Pain Swelling Cavities Sores in Mouth

Sealants Fillings Injured Teeth Extracted Teeth "Crooked Teeth"

How do you predict your child will behave? Cooperative Fearful Defiant Don't know

What is the reason for today's visit? _____

Does your child have any of the following habits?

- Pacifier use
- Thumb/finger sucking
- Lip sucking/biting
- Nail biting
- Nursing/bottle habits
- Mouth breathing
- Nighttime grinding of teeth

REFERRAL INFORMATION:

Whom may we thank for referring you to our practice?

Google Drive By School Work

Doctor's Office _____ Dental Office _____

Neighborhood Newsletter _____

Another Patient _____ Other _____

DENTAL INSURANCE:

Dental Insurance Co. _____

Insurance Co. Phone #: _____

Group#: _____

Insured's Name: _____

Insured's DOB: _____

Insured's SSN: _____

Insured's ID #: _____

Relationship to Patient: _____

Employer: _____

For our patients with dental insurance, we will be happy to file insurance claims for you as long as your insurance can be verified. We ask you to pay all non-covered fees as treatment progresses.

Signature of Parent/ Guardian _____ Date _____



Dr. Jennifer L. Kiening
10510 W. Parmer Lane, Suite 100, Austin TX, 78717

Office Billing and Insurance Policies

Payments

Payments are due the day services are performed. Payment is accepted in the form of cash, check, debit cards, or credit cards (Visa, Master Card, Discover, or American Express). If you would like to keep an account on file with us, please fill in appropriately below.

Card# _____ Exp: _____ Vcode: _____

Insurance

Your insurance plan is an agreement between *your insurance company and you*. We file claims to your insurance company as a courtesy to you. After 30 days, we ask that you call your insurance company if no payment has been received. After 60 days, any outstanding insurance balance will be your responsibility. Also, please understand, you are responsible for the balance of charges incurred regardless of your insurance payment.

Billing

You may incur a finance charge of 1.5% on your account if your balance is not paid in 60 days or less. Please inform us of any financial concerns so an agreement can be made up front of how the account will be paid. I also agree that should it become necessary to forward my account for collections, in addition to the amount owed I will also be responsible for the fees associated with the costs of collections.

Authorization

I have read and understand the above written financial policy; I hereby authorize payment of insurance benefits directly to Little Smiles Pediatric Dentistry, otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment not covered by insurance. The responsible party is the parent/or guardian that brings the child to the dental office and seeks treatment, independent of what a divorce decree may state. Reimbursement must be made between divorced parties; we will not intervene.

Signature of Responsible Party

Date



Dr. Jennifer L. Kiening
10510 W. Parmer Lane, Suite 100 Austin TX, 78717

Health Information Privacy Policy Act (HIPPA)

Child/Children's Names: _____

Parent/Guardian's Name: _____

Phone#: _____ Work: _____ Cell: _____

Address: _____

In General, the HIPPA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply)

Home Telephone:

- Ok to leave message with details
- Ok to speak to spouse/sibling

Written Communication:

- Ok to mail to my home
- Ok to fax to designated #

Work Telephone:

- Ok to leave message with details
- Leave message with call back

I give Dr. Kiening permission to use and disclose PHI necessary to carry out TPO (Treatment Payment or Operations) this also indicated a "Good Faith Effort" was made on behalf of Dr. Kiening. By signing this form, I understand that the privacy practices of the office have been disclosed to me. This information will stay on record for six years.

Signature

Date



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Conformation and Missed Appointment Policy

We are dedicated to provide the best dental care possible for your child. We want to give your child the time and INDIVIDUAL attention they deserve. In a sincere effort to acknowledge the importance of each parent's time, and to remain on time during our busy schedule, we must ask the parents ARRIVE ON TIME FOR THEIR CHILDREN'S APPOINTMENT. This allows us to be able to see all the children that are scheduled in a timely and efficient way. When a parent is *late* or *fails* to make a scheduled appointment, this may jeopardize all the children's treatment. It also affects other parent's schedules that have children scheduled after your child that day.

- Please call our office if you are going to be late for your appointment.
- If a patient is more than 15 minutes late we may need to reschedule the appointment. If we are able to see your child, we cannot guarantee that all treatment will be completed.

In an effort to serve all children that have dental needs, we must ask that you acknowledge our missed appointment policy. A Time is specifically set aside for your child's dental appointment, should you miss a restorative appointment you will be assessed a "missed appoint" fee of \$50.00 at that time, you will be rescheduled for the missed appointment, and will be required to prepay your child's next appointment.

- Parents may change or cancel their child's appointment with at least 24 hours notice.

Parent/Guardian Signature

Date