William A. Keaty DDS
Anita J. Gouri DDS
Board Certified Specialists
Pediatric Dentistry

Welcome!

350 Doucet Road, Ste. 101
Lafayette, LA 70503
P: (337) 981-9242 F: (337) 981-7505
nocavitykids.com

Please Print Legibly — Patient Information — Today's Date_____

Name_____
First Middle Last Nickname

Is Child Adopted?____ **If yes, does he or she know?**_____ **School/Daycare:** _____

Address_____
Street City State Zip

Age _____ **Date of Birth** _____ **Sex:** M / F Race: _____ Primary Language:_____

SSN_____

Other children in your family that we may have seen_____

_____

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

Responsible Party Information

Legal Guardian/Parent Name_____ **Marital Status** _____
First Last

Address _____
(if different) Street City State Zip

Relationship to patient _____ **Date of Birth** _____ **SSN**_____

Email address _____ **Home Phone** _____ **Cell Phone** _____

Employer_____ **Occupation** _____**Work Phone**_____

Other Guardian Name_____ **Marital Status** _____
First Last

Address _____
(if different) Street City State Zip

Relationship to patient _____ **Date of Birth** _____ **SSN** _____

Email address_____ **Home Phone** _____ **Cell Phone** _____

Employer_____ **Occupation** _____ **Work Phone**_____

Dental Insurance Information

Insured's Name_____ **Insured's DOB**_____ **Insured's SSN** _____
Insurance Company _____**Policy #**_____ **Group #**_____
Insurance Co. Address_____
Insurance Co. Phone # _____
Insured's Employer_____

Emergency Contact

In case of an emergency, whom may we contact?
Name_____ **Phone**_____
Address_____
_____

William A. Keaty DDS **Anita J. Gouri DDS**

Please print legibly **Medical History** **Today's Date_____**

How is your child's general health?_____ Up to date on immunizations?_____ Approx. Wt. _____
Who is your child's physician?_____ Phone # _____
Address_____
Has your child been hospitalized (since birth)? Y / N. If so, please list reason(s) _____
_____
Please list any **Medications, Vitamins or Herbal Supplements** your child currently takes:
(RX and over the counter, name, dosage, frequency and date started) _____
_____
Please list any **allergies** your child has: _____
_____
Has your child or anyone in your family had any unfavorable reactions to any medications or any type of anesthesia? Y / N
If so, please name substance and type of reaction(s): _____
_____Date of reaction _____ Dr. who treated reaction_____
Outcome_____
Please indicate if your child has or has had any of the following, and explain in the space provided below:

___1. Anemia
___2. Asthma
___3. Autism/Asperger's Syndrome
___4. ADD/ADHD
___5. Behavioral Problems
___6. Bleeding Problems
___7. Blood Transfusions
___8. Cancer
___9. Cerebral Palsy
___10. Cleft Lip/Palate
___11. Cystic Fibrosis
___12. CSF Shunt
___13. Developmental Delay
___14. Diabetes
___15. Downs Syndrome
___16. Earaches (frequent)
17. Headaches
___18. Hearing Disorder
___19. Heart Condition
Type: _____
Antibiotic Required? ____
___20. Hepatitis
___21. High Blood Pressure
___22. HIV+/Aids
___23. Hormonal Problems
___24. Hypoglycemia
___25. Hyperglycemia
___26. Kidney Disease
___27. Latex Allergy
___28. Liver Disorder
___29. Lung Disorder
___30. Mental Condition
___31. Metabolic Disorder
___32. Muscular Dystrophy
___33. Pregnancy
___34. Premature Birth
___35. Rheumatic Fever
___36. Scoliosis
___37. Seizure Disorder
___38. Sickle Cell Anemia/Trait
___39. Skin Problems (eczema)
___40. Sleep Apnea
___41. Speech Disorder
___42. Stomach Problems
___43. Thyroid Disorder
___44. Tuberculosis
___45. Vision Problems
___46. Other_____
.

_____
_____

Dental History

Is this your child's first dental visit? ___ If not, date of last visit was _____. Was it a favorable visit?_____
If it wasn't favorable, please explain: _____
_____
Does your child currently use a Pacifier? Y / N. Suck his/her thumb or fingers? Y / N. Take a bottle? Y / N
Please indicate if your child is taking fluoride in any of the following forms:
Mouth rinse____ Drops or tablets ____ Within their multivitamin ____ In their water ____ Toothpaste____ Other ____
Has your child had any trauma to their teeth or face? ___ If so when?_____
What is the main reason for today's visit?_____
Is your child currently experiencing any dental pain? Y / N. Please describe: _____
_____
Please use this space to make us aware of anything else that would help us understand and treat your child better:
_____

By signing below, you affirm that the information you have given is correct to the best of your knowledge. It is your responsibility to inform this office of any changes in your child's medical status.

Parent or Legal Guardian Signature_____ Date_____

Keaty and Gouri Pediatric Dentistry

Non-Legal Guardian Patient Escort Form

****Please complete this form if you anticipate that someone else will need to bring your child to future checkups or treatment appointments. This should be a responsible adult who can make decisions about your child's/children's dental needs on your behalf.**

Today's Date: _____

Name of Patient(s):_____

DOB of Patient (S): _____

I, _____, the parent/legal guardian of _____, authorize my child/children to be escorted to their dental appointment by _____.
I authorize this person to provide consent for any proposed dental treatment and to provide updated medical history information for my child.

I authorize Keaty and Gouri Pediatric Dentistry's staff and dentists to examine, take X-rays, perform dental cleaning, and apply fluoride to my child. I also authorize the dentists to perfom any proposed dental treatment including but not limited to stainless steel crowns, fillings, extractions, and the administration of local anesthesia, nitrous oxide, and medications appropriate for mild oral conscious sedation.

Escort Name and Relation to Patient _____

Phone number of **Parent/Legal Guardian**_____

****please be available by phone during child's/children's appointment.**

Name of Parent/Legal Guardian_____

Signature of Parent/Legal Guardian_____Date_____

William A. Keaty, DDS
350 Doucet Road, Suite 101
Lafayette, LA 70503
337-981-9242

FINANCIAL POLICY

Treatment

Here in Dr. Bill Keaty's office your child's dental health is always the primary concern. In the event your child should require treatment, our office provides full-time financial coordinators who will work with you to determine your benefits and ensure that the necessary treatment is financially feasible.

At the time treatment is recommended you will be referred to a coordinator who will review your personal needs and present financing options that fit your budget, including interest free financing for those who qualify. We are committed to assisting you and providing you with any information necessary to maximize your insurance benefits. We accept cash, checks, Visa, MasterCard, Discover and American Express.

Dental Insurance

As a courtesy, our office routinely files all dental claims on your behalf. Also, we accept assignment of benefits from all insurance companies that allow us to receive assignment**. Please be advised that we are not contracted with any insurance companies or dental plans. You will be responsible for any amount that your insurance company does not assign to us or is not covered by your insurance company.** This includes any difference between your insurance company's allowances and our fees.

Notice

In the event an account is turned over for collections, as permitted by Louisiana State law, the responsible party will be financially responsible for any collection charges incurred as a result of the collection activity. Also, an additional fee of $30.00 will be charged for any check returned to our office unpaid by your financial institution. Should you have any questions regarding our financial policy, we encourage you to discuss them with our staff.

I have read and understand Dr. William A. Keaty's financial policy and agree to comply accordingly.

Patient Name:_____

Responsible Party: _____

Relationship to Patient: _____

Date: _____

William A. Keaty, D.D.S., A Professional Dental Corporation

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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/17/2001, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information: We use and disclose health information about you without authorization for the following purposes.

Treatment: We may 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 to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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, and certification, licensing or credentialing activities.

To You or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for

certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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).

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $15.00 per hour for staff time to 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 health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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 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 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: Stacey Williamson
Telephone: 337-981-9242
Fax: 337-989-2737
E-mail: staceyw@nocavitykids.com
Address: 350 Doucet Road, Suite 101, Lafayette, LA 70503

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

WILLIAM A. KEATY, DDS

I acknowledge that I have received a copy of your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand William A. Keaty, DDS has the right to change the information contained in the notice from time to time and that I may contact the office to obtain the most current copy of your Notice of Privacy Practices, which is posted in the waiting room. I also acknowledge that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy and have the right to access my health information. I have also been informed of my right to have any of this information clarified by your office and have been given the contact information of your privacy officer.

_____

Patient Name (Please Print)

_____ _____

Signature of Legal Guardian/Parent **Date**

_____

Relationship to Patient

Please complete the following brief questionnaire to assist our office in developing a personalized communication system with you regarding your child's care in our office.

1. How would you like your appointments confirmed? Email Phone Both
2. If by email, please indicate the email address you would like to use: _____
3. What is the best number to contact you between 8-5? _____
4. What alternate number should we use? _____
5. May we voicemail on the above numbers? Yes No
6. If we cannot reach you at the number above may we contact you at work? Yes No
7. Who is legally responsible for making treatment decisions for your child? Please list person's name and relationship to the child _____
8. Is there anyone, outside the legal guardians, that we may discuss your child's treatment with?

   _____ _____
   Name Relationship to Child

   _____ _____
   Name Relationship to Child
9. Are there any issues regarding confidentiality or communication with our office that you would like us to consider? _____

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)

_____

_____

_____

William A. Keaty DDS & Anita J. Gouri DDS
Pediatric Dentistry
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GENERAL INFORMATION AND CONSENT

We are pleased to receive your child as a patient in our office and feel honored by the confidence you have placed with us. We sincerely desire to make his or her visits as pleasant as possible. We feel that we can better establish patient-doctor relationships if our parents and patients are familiar with the service and procedures of this office.

INITIAL VISIT: Each child receives a thorough examination on their first appointment. It usually includes a prophylaxis (cleaning of the teeth), topical fluoride, and dental x-rays, if they are needed. Oral hygiene instructions will be given to the patient and reviewed with the parent along with dietary recommendations. We employ all procedures available to reduce radiation risk including thyroid and gonadal lead apron, collimated x-ray machine, and the fastest film available today. We feel that it is extremely important for a child to have a full mouth x-ray (panorex) starting around the age of 5 or 6 to check for any problems such as extra permanent teeth, congenially missing teeth, cysts, or eruption problems.

PARENTS MAY ACCOMPANY THEIR CHILD: We have an open door policy in our practice. We want our parents to participate in their child's dental education and feel that it is important that they support our recommendation. We feel that we can prevent most of your child's dental problems with a team effort.

NITROUS OXIDE (LAUGHING GAS): Frequently, we will employ the "Happy Air Mask" (nitrous oxide) to help reduce anxiety and fear of dental procedures. It is tremendously effective when treating children and is very safe.

PREMEDICATION: It is sometimes necessary to premedicate young children with sedatives in order to successfully perform certain dental procedures. If we recommend premedication, the medications and anticipated side effects will be carefully explained before the procedure. Children who have been premedicated will have their vital signs monitored throughout the procedure.

HOSPITALIZATION: Some young or handicapped children requiring extensive treatment would benefit by having their work done under general anesthesia in the hospital setting. If we feel that this is a necessary way to treat your child, we will thoroughly discuss hospitalization with you.

PREVENTIVE DENTISTRY: Since some areas of South Louisiana are not adequately fluoridated, preventive dentistry is extremely important. The American Academy of Pediatric Dentistry recommends that children who live in a non-fluoridated areas routinely take fluoride supplements (Poly-vi-flor, Luride, Phos-fur, etc) until the age of ten. Fluoride helps strengthen the teeth as they develop. Also, home fluoride rinse is recommended to strengthen the teeth that are presently in the mouth. We highly recommend sealants for the permanent molars and some second primary molars after eruption.

ORTHODONTICS: At each six month hygiene appointment your child will be checked for proper eruption of teeth and/or any malocclusion that may be developing. We will inform you of any treatment that we feel is necessary for your child.

CHILDREN'S TIME: Although we schedule appointment times for the treatment of your child, our office operates on"children's time". This means that occasionally some of our patients who are not particularly interested in getting their dental work done may take extra time to be made more comfortable and less apprehensive. This will invariably play havoc with our schedule and cause some delays. So let me personally apologize for running behind

now! We are guilty of letting our patients manipulate the schedule somewhat when we are trying to give them the best possible dental experience. We also see many emergencies since children may have accidents at home, school or play.

APPOINTMENT POLICY: As a growing pediatric dental practice, our schedule is sometimes booked several months in advance. While we understand that some appointments can't be kept, we would like the courtesy of a phone call notifying us so that we may give that appointment to another child.

PLEASE LET US KNOW IF YOU OBJECT TO THE USE OF FLUORIDE AND/OR X-RAYS. We intend to render dental services to your child as we would our own. If, at any time, you have any questions concerning your child's dental health, please feel free to ask.

I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS FORM

Parent's Signature _____ Child'sName_____

Reviewed by _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
* You May Refuse to sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices on behalf of my child/children.

Parent Name_____

Signature_____ Date _____

Child/Children's Name(s)_____

_____

For Office Use Only

We attempted to obtain written acknowledgment 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