

**About You**

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Today's Date \_\_\_\_\_

Name: \_\_\_\_\_

I prefer to be called: \_\_\_\_\_ Male  Female

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer phone: \_\_\_\_\_ Yrs emp: \_\_\_\_\_

Occupation: \_\_\_\_\_

Whom may we thank for referring you?  
\_\_\_\_\_

Other family members seen by us?  
\_\_\_\_\_

**Spouse Information**

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Name: \_\_\_\_\_

Address if different than above:  
\_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

**Responsible Party**

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Are you responsible for the account? Yes  No

Name of person responsible for account:  
\_\_\_\_\_

Billing Address if different than above:  
\_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

**Emergency Contact**

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Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**Insurance Coverage**

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**Primary**

Ins. Co. Name: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

Ins. Co. Phone: \_\_\_\_\_

Group/Plan ID: \_\_\_\_\_

Policy ID: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Subscriber's Birthdate: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

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**Secondary**

Ins. Co. Name: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

Ins. Co. Phone: \_\_\_\_\_

Group/Plan ID: \_\_\_\_\_

Policy ID: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Subscriber's Birthdate: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

**Dental History**

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Last dental visit: \_\_\_\_\_ Cleaning: \_\_\_\_\_

Do you require pre-med before dental treatment?  
Yes  No

Do you wear dentures or partials? Yes  No

Is there anything about your smile you would change?  
Yes  No

Do you snore or have sleep apnea? Yes  No

Have you had orthodontic treatment? Yes  No

Do you grind or clench your teeth? Yes  No

Have you ever had pain in your jaw, face or around your ear? Yes  No

Do you have frequent headaches? Yes  No

Does your jaw joint click or pop? Yes  No

Do you have difficulty opening widely? Yes  No

Do you have unpleasant odor or taste in your mouth?  
Yes  No

### Dental History *(continued)*

Do your gums bleed when you brush? Yes  No

Have you ever been diagnosed with gum disease?

Yes  No

Is your mouth sensitive to pressure? Yes  No

Cold? Yes  No  Hot? Yes  No

Does food catch in your teeth? Yes  No

Do you have difficulty getting numb for dental treatment? Yes  No

Please add anything else you feel is important for the doctor to know: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Financial Agreement

I acknowledge that payment is due in full at the time of treatment unless prior arrangements have been made.

\_\_\_\_\_  
Initials

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover.

\_\_\_\_\_  
Initials

### Insurance Acknowledgement

Your dental insurance provider may change the dental codes, downgrade, or pay on an alternative treatment option. If this happens, then based on State of Nebraska LB 810:44-7,105, it voids any contractual agreement with this office or any other dental office. You will be responsible for the difference from our fee less the amount insurance pays.

\_\_\_\_\_  
Initials

### Cancellation/No Show Policy

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment that you please provide us with at least a 24 hour notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

We reserve the right to charge a \$50.00 cancellation fee for late cancellations or missed appointments. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

\_\_\_\_\_  
Initials

### Treatment Authorization

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

\_\_\_\_\_  
Initials

### Notice of Privacy Practices

I acknowledge that I have received or been offered a copy of the *Notice of Privacy Practices* from Stec & Stines Cosmetic and Family Dentistry, LLC.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date