STEC STINES
COSMETIC FAMILY DENTISTRY

About Your Child

Today's Date _____

Child's Name: _____

Nickname:_____ Male ☐ Female ☐

Birthdate:_____Age:__SSN:_____

Address:_____

City:_____St:____Zip:_____

Phone:_____Cell: _____

Whom may we thank for referring you?

_____

Other family members seen by us?

_____

Who is Accompanying the Child Today

Name:_____Relation:_____

Do you have legal custody of this child? Yes☐ No☐

Mother's Information

Name:_____

Step Mother☐ Guardian☐

Phone:_____ Work:_____

Employer:_____

SSN:_____

Parent's Marital Status: Single☐ Married☐ Divorced☐ Widowed☐ Separated☐

Father's Information

Name:_____

Step Father☐ Guardian☐

Phone:_____ Work:_____

Employer:_____

SSN:_____

Responsible Party

Name of person responsible for account:

_____

Billing Address if different than above:

_____

City:_____St:____ Zip:_____

Relation to patient:_____

Insurance Coverage

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:_____

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

Last Dental Visit:_____

Has the child ever had a serious/difficult problem associated with any dental work? Yes☐ No☐

Is the child's water fluoridated? Yes☐ No☐

Is the child taking fluoride supplements? Yes☐ No ☐

Has the child had orthodontic treatment? Yes☐ No☐

Does the child grind or clench their teeth? Yes☐ No☐

Has the child ever had pain or tenderness in the jaw joint? Yes☐ No☐

Does the child brush their teeth daily? Yes☐ No☐

Floss their teeth daily? Yes☐ No☐

Do the child's gums bleed when they brush? Yes☐ No☐

Does the child take gummy vitamins? Yes☐ No☐

Dental History (*continued)*

Does the child thumb suck? Yes☐ No☐
Does the child suck or bite their lips? Yes☐ No☐
Does the child bite their nails? Yes☐ No☐
Is the child still using a bottle or pacifier? 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 180:44-7,105, 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 child's medical status.

_____
Signature Date

Stec & Stines Cosmetic and Family Dentistry

Medical History

Patient Name: _____ Birth Date: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Physician?	❍ Yes	❍ No	If yes
Have you ever been hospitalized or had a major operation?	❍ Yes	❍ No	If yes
Have you ever had a serious head or neck injury?	❍ Yes	❍ No	If yes
Are you taking any medications, pills or drugs?	❍ Yes	❍ No	If yes
Do you take a pre-med medication?	❍ Yes	❍ No	If yes
Are you taking blood thinners?	❍ Yes	❍ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	❍ Yes	❍ No	If yes
Are you on a special diet?	❍ Yes	❍ No	
Do you use tobacco?	❍ Yes	❍ No	

Women: Are you…

❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic
❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Local Anesthetics
❑ Erythromycin

Do you use controlled substances?	❍ Yes	❍ No	If yes
Other?	❑		If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	❍ Yes	❍ No	Cortisone Medicine	❍ Yes	❍ No	Hemophilia	❍ Yes	❍ No	Radiation Treatments	❍ Yes	❍ No
Alzheimer's Disease	❍ Yes	❍ No	Diabetes	❍ Yes	❍ No	Hepatitis A	❍ Yes	❍ No	Recent Weight Loss	❍ Yes	❍ No
Anaphylaxis	❍ Yes	❍ No	Drug Addiction	❍ Yes	❍ No	Hepatitis B or C	❍ Yes	❍ No	Renal Dialysis	❍ Yes	❍ No
Anemia	❍ Yes	❍ No	Easily Winded	❍ Yes	❍ No	Herpes	❍ Yes	❍ No	Rheumatic Fever	❍ Yes	❍ No
Angina	❍ Yes	❍ No	Emphysema	❍ Yes	❍ No	High Blood Pressure	❍ Yes	❍ No	Rheumatism	❍ Yes	❍ No
Arthritis/Gout	❍ Yes	❍ No	Epilepsy or Seizures	❍ Yes	❍ No	High Cholesterol	❍ Yes	❍ No	Scarlet Fever	❍ Yes	❍ No
Artificial Heart Valve	❍ Yes	❍ No	Excessive Bleeding	❍ Yes	❍ No	Hives or Rash	❍ Yes	❍ No	Shingles	❍ Yes	❍ No
Artificial Joint	❍ Yes	❍ No	Excessive Thirst	❍ Yes	❍ No	Hypoglycemia	❍ Yes	❍ No	Sickle Cell Disease	❍ Yes	❍ No
Asthma	❍ Yes	❍ No	Fainting Spells/Dizziness	❍ Yes	❍ No	Irregular Heartbeat	❍ Yes	❍ No	Sinus Trouble	❍ Yes	❍ No
Blood Disease	❍ Yes	❍ No	Frequent Cough	❍ Yes	❍ No	Kidney Problems	❍ Yes	❍ No	Spina Bifida	❍ Yes	❍ No
Blood Transfusion	❍ Yes	❍ No	Frequent Diarrhea	❍ Yes	❍ No	Leukemia	❍ Yes	❍ No	Stomach/Intestinal Disease	❍ Yes	❍ No
Breathing Problems	❍ Yes	❍ No	Frequent Headaches	❍ Yes	❍ No	Liver Disease	❍ Yes	❍ No	Stroke	❍ Yes	❍ No
Bruise Easily	❍ Yes	❍ No	Genital Herpes	❍ Yes	❍ No	Low Blood Pressure	❍ Yes	❍ No	Swelling of Limbs	❍ Yes	❍ No
Cancer	❍ Yes	❍ No	Glaucoma	❍ Yes	❍ No	Lung Disease	❍ Yes	❍ No	Thyroid Disease	❍ Yes	❍ No
Chemotherapy	❍ Yes	❍ No	Hay Fever	❍ Yes	❍ No	Mitral Valve Prolapse	❍ Yes	❍ No	Tonsillitis	❍ Yes	❍ No
Chest Pains	❍ Yes	❍ No	Heart Attack/Failure	❍ Yes	❍ No	Osteoporosis	❍ Yes	❍ No	Tuberculosis	❍ Yes	❍ No
Cold Sores/Fever Blisters	❍ Yes	❍ No	Heart Murmur	❍ Yes	❍ No	Pain in Jaw Joints	❍ Yes	❍ No	Tumors or Growths	❍ Yes	❍ No
Congenital Heart Disorder	❍ Yes	❍ No	Heart Pacemaker	❍ Yes	❍ No	Parathyroid Disease	❍ Yes	❍ No	Ulcers	❍ Yes	❍ No
Convulsions	❍ Yes	❍ No	Heart Trouble/Disease	❍ Yes	❍ No	Psychiatric Care	❍ Yes	❍ No	Venereal Disease	❍ Yes	❍ No
Yellow Jaundice	❍ Yes	❍ No									

Have you ever had any serious illness not listed ❍ Yes ❍ No If yes _____

Emergency Contact and Phone Number: _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date: _____