STEC SS 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.

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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.

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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.

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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.

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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.

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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