



Stec Cosmetic and Family Dentistry, LLC

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 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

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