Stec Cosmetic and Family Dentistry, LLC

About You

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

Name: _____

Address if different than above:

_____

City: _____ St: ____ Zip: _____

Phone: _____ Cell: _____

Birthdate: _____ SSN: _____

Employer: _____

Employer Phone: _____

Responsible Party

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

Name: _____

Relationship: _____

Phone: _____

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: _____ 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 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 medical status.

_____
Signature Date

Stec Cosmetic and Family Dentistry, LLC

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: _____