

Nebraska Family Dentistry

— ALL LOCATIONS —

Changing Dentistry, Changing Lives



New Child Patient Form

Child / Minor Information

Name of Child/Minor: _____ SS#: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Sex: M F Age: _____ Birth Date: _____
 School Name: _____
 Person Financially Responsible: _____
 Parent's email for communication: _____
 How did you hear about our office?: _____

Dental Insurance / Parent Information

Father's Name: _____	Mother's Name: _____
Address: _____	Address: _____
Phone Number: _____	Phone Number: _____
S M D	S M D
Employer: _____	Employer: _____
Work Phone: _____	Work Phone: _____
SS#: _____	SS#: _____
Birth Date: _____	Birth Date: _____
Email: _____	Email: _____
Do you have Dental Insurance Coverage for the Child/Minor?: Y N	Do you have Dental Insurance Coverage for the Child/Minor?: Y N

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Alderman all Insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-name dentist may use my health care information and disclose such information to the above-named insurance company and their agents for the purpose obtaining payments for services and determining insurance benefits of the benefits payable for release services. This consent will end when my current treatment plan is complete or one year from the date signed below.

Signature of Parent/ Guardian: _____

Health History

Physician's Name: _____ Date of last visit: _____

Please indicate if your child **has** or **had** any of the following:

- | | | |
|------------------------|--------------------------|-------------------------|
| AIDS/HIV | Emphysema | Heart Trouble/Attack |
| Allergy | Epilepsy or Convulsions | Immune System Disorder |
| Anemia | Fainting Spells/Seizures | Kidney Trouble |
| Artificial Heart Valve | Family History of | Prolapsed Mitral Valve |
| Artificial Joint | Malignant Hyperthermia | Radiation Treatment |
| Asthma | Fever Blisters | Rheumatic Heart Disease |
| Bleeding Problems | Glaucoma | Pacemaker |
| Blood Transfusion | Heart Defeat or Murmur | Sinus Trouble |
| Cancer | High Blood Pressure | Stroke |
| Chemotherapy | Hepatitis A (infectious) | Taken Cortisone in Past |
| Cold Sores | Hepatitis B (serum) | Year Tuberculosis |
| Diabetes | Herpes | Ulcers |

Do you smoke? Yes No Have you taken bisphosphonate drugs? Yes No

Other: _____

Medications:

List any medications your child may currently be taking and the correlating diagnosis:

Allergies:

Aspirin Acrylic
Codeine Latex
Local Anesthetics Sulfa Drugs
Penicillin Metals

Other allergies: _____

Woman:

Are you pregnant? Yes No Due Date: _____

Are you nursing? Yes No

Taking birth control pills? Yes No

Is there anything else we should know? _____

Please let us know if you would like a copy of Notice of Privacy Practices HIPAA that is offered to all of our patients.

Please list any other person(s) that have permission to access your records and account information:

We are pleased to welcome you to our practice! _____

Signature of patient or parent/guardian