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: ◯ Male ◯ Female ◯ Other Age: _____ Birth Date: _____

School Name: _____ Grade: _____

Who would you like us to contact for communication: _____

Person Financially Responsible: _____

How did you hear about our office?: _____

Parent Information

Father's Name: _____

Address: _____

Phone Number: _____

Employer:_____

Work Phone: _____

SS#: _____

Birth Date: _____

Email: _____

Mother's Name: _____

Address: _____

Phone Number: _____

Employer:_____

Work Phone: _____

SS#: _____

Birth Date: _____

Email: _____

Dental Insurance Information:

Name of Policyholder_____

Policyholder's DOB_____ Policyholder's SS#_____

Policyholder's Employer_____ Relationship to Patient_____

Policy ID Number _____ Group Number _____

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Nebraska Family Dentistry 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-named office may use my health care information and disclose such information to the above-named insurance company and their agents for the purpose of obtaining payments for services and determining insurance benefits of the benefits payable for release services.

Health History

Physician's Name_____ Date of last visit_____

Preferred Pharmacy: _____ Location _____

*Please indicate if you **have** or **have had** any of the following:

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

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

Other:_____

Medications: *List any medications you are currently taking and the correlating diagnosis*

_____

_____

_____

Allergies:

○Aspirin ○ Codeine

○Local Anesthetics ○ Penicillin

○Acrylic ○ Latex / Rubber

○Sulfa Drugs ○ Metals

○Other allergies: _____

Women:	**Yes**	**No**
Are you pregnant?	○	○
Due Date: _____		
Are you nursing?	○	○
Taking birth control?	○	○

If so, is there anything else we should know?

_____

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

_____

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

We are pleased to welcome you to our practice!_____

(Signature of patient or parent / guardian)