Pine Ridge Dental

*5140 S. 56th St. Lincoln, NE 68516 *8545 Executive Woods Dr. Lincoln, NE 68512*

*Phone: 402.423.1100 * Fax: 402.423.1368 * www.pineridgedental.com*

Child Health/Dental History Form

Patient's Name:	Nickname:		Today's Date:	
Parent / Guardian Name:	Relationship to Patient:	Home Phone: ( )	Cell Phone: ( )	
Address:	City:	State:	Zip:	
Email:	Height:	Weight:	Date of birth:	Sex: M F

Have you or the patient had any of the following diseases or problems?	**Yes**	**No**
1. Active Tuberculosis, 2. Persistent Cough greater than a 3 week duration, 3. Cough that produces blood	☐	☐

If you answer yes to any of the items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV+/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco / Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex Allergy	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other _____
☐ Bones / Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle Cell	

Please list the name and phone number of the child's physician:

Name of Physician: _____ Phone: _____

Child's History

	Yes	**No**
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	☐	☐
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	☐	☐
3. Is the child allergic to anything else such as certain foods? If yes, please explain: _____	☐	☐
4. How would you describe the child's eating habits: _____		
5. Has the child ever been hospitalized? Please describe: _____	☐	☐
6. Does the child have a history of any other illnesses? If yes, please list: _____	☐	☐
7. Has the child ever received general anesthetic?	☐	☐
8. Does the child have any speech difficulties?	☐	☐
9. Has the child ever had a blood transfusion?	☐	☐
10. Is the child physically, mentally, or emotionally impaired?	☐	☐
11. Does the child experience excessive bleeding when cut?	☐	☐
12. Is the child currently being treated for any illnesses?	☐	☐
13. Is this the child's first visit to a dentist? If not the first visit, when was the date of the last dental visit?	☐	☐
14. Has the child had any problem with dental treatment in the past?	☐	☐
15. Has the child ever had dental radiographs (x-rays) taken?	☐	☐
16. Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
17. Has the child had any problems with the eruption or loss of baby teeth?	☐	☐
18. Has the child had any orthodontic treatment?	☐	☐
19. What type of water does your child drink? ☐ City Water ☐ Well Water ☐ Bottled Water ☐ Filtered Water		
20. Does the child take fluoride supplements?	☐	☐
21. Is fluoride toothpaste used?	☐	☐
22. How many times are the child's teeth brushed per day? _ When are the teeth brushed? _____		
23. Does the child suck his/her thumb, fingers or pacifier?	☐	☐
24. At what age did the child stop bottle feeding? ____ Breast feeding? _____		
25. Does the child participate in active recreational activities?	☐	☐

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:	**Date:**

PLEASE TURN OVER TO COMPLETE FORM

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Insurance, Financial Options, and Appointment Agreement

Patient Name:	Date of Birth:

Dental Insurance

As a courtesy, we will process your insurance benefits for you. All questions regarding your insurance coverage must be addressed by you with your insurance carrier. We will provide you with a treatment plan that lists dental codes, procedures and fees so that you can call your insurance carrier for estimates. Insurance companies never guarantee benefits. We will estimate your copay as closely as possible, and anything they do not pay is your responsibility. **I understand that my estimated portion that is not covered by my insurance is due at the time services are provided.** _____ (Initial)

Primary Insurance Coverage

Policy Holder: _____

Employer: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Phone: _____ Group #: _____

Policy Holder ID#: _____ Date of Birth: _____

Secondary Insurance Coverage

Policy Holder: _____

Employer: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Phone: _____ Group #: _____

Policy Holder ID#: _____ Date of Birth: _____

Financial Options

We are committed to supporting you in understanding your dental health, and will always present you with the best dental options possible to address your personal health situation. To make these services comfortably affordable, we are pleased to offer you the following patient options:

1. 5% Courtesy fee reduction for pre-payment in full for services paid by cash or check
2. Cash, Check
3. Visa, MasterCard, Discover
4. No interest payment plans with *CareCredit* up to 12 months

I agree that I am fully responsible for the total amount of all procedures performed at Pine Ridge Dental, including all dental care that is not a covered benefit by my dental carrier. I understand that all services are due within 60 days of the date of service, regardless of whether or not my insurance has paid. I understand that at 60 days my account will accrue interest of 1.3% per month (not more than 16% annually) and balances over 90 days are subject to collection activity. _____ (Initial)

Appointment Agreement

We value your time and reserve a set amount of time in our schedule to ensure you receive quality care. Should you need to cancel or change your appointment, **we ask for a 24-hour notice. Otherwise, you could be subject to a $35 broken appointment fee.** Our goal is that you have an outstanding experience at Pine Ridge Dental. If you have additional questions, please speak to one of our administrative team members for further information.

_____ _____

Patient / Parent / Legal Guardian Signature Date