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

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

Child's name:_____ Today's Date:_____

Name preference:_____ ☐ Male ☐ Female

Referred to Pine Ridge Dental through:_____

Birthdate:_____ Age:_____ SSN:_____

Home Address:_____
Street City State Zip

Person responsible for child's account:_____ Relationship:_____

Billing Address (if different):_____
Street City State Zip

Primary Contact:_____ Relationship:_____ Phone:_____
☐ Call ☐ Text

E-mail: _____

Secondary Contact:_____ Relationship:_____ Phone:_____
☐ Call ☐ Text

Emergency Contact:_____ Relationship:_____ Phone:_____

Medical Information

Physician's Name:_____ Phone: _____

Date of last physical exam:_____

Is your child currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

_____

Is your child currently taking any medications?
☐ Yes ☐ No If yes, please list or attach on a separate sheet

_____

_____

_____

For teens, are you pregnant? ☐ Possibly ☐ Yes ☐ No If yes, week#: __

Does your child need to be pre-medicated with antibiotics before dental treatment? ☐ Yes ☐ No
If yes, what is the Pre-Med for? _____

Has your child had serious medical problems? ☐ Yes ☐ No
If yes please explain _____

_____

Check box if you have had any history of or conditions related to, any of the following:

☐ Anemia	☐ Drug/Alcohol abuse	☐ Hyperthyroid
☐ Arthritis	☐ Dental Anxiety	☐ Hypothyroid
☐ Asthma/Respiratory problems	☐ Epilepsy/Seizures	☐ Kidney disease
☐ Bladder	☐ Fainting spells	☐ Liver disease
☐ Cancer/Tumors	☐ Fever blister/cold sores	☐ Psychiatric disorders
☐ Cerebral Palsy	☐ Growth problems	☐ Sickle cell disease
☐ Chicken pox	☐ Hearing problems	☐ Sight problems
☐ Chronic sinus problems	☐ Heart	☐ Tobacco use, how much?__
☐ Chronic Hepatitis	☐ Hemophilia /bleeding	☐ Transplant
☐ Chemo/Radiation	☐ HIV+/AIDS	☐ Tuberculosis
☐ Diabetes	☐ Human papilloma virus	☐ **NONE**

Has your child experienced any other conditions that are not listed above? ☐ Yes ☐ No If yes, please list: _____

_____

_____

Allergies:

☐Penicillin/Amoxicillin	☐Erythromycin	☐Dental anesthetics
☐Aspirin	☐Tetracycline	☐Codeine
☐Sulfa drugs	☐Cephalosporins	☐Clindamycin
☐Jewelry/Nickel	☐Latex (rubber)	☐Other, please list
	☐Sulfur drugs	

Is your child allergic to any medications or products not listed above?

☐ Yes ☐ No If yes, please list _____

_____

_____

Dental Information

Why have you come to the dentist today?

_____

_____

If this is not your first visit, when were your child's teeth last cleaned? _____

Has your child had complication or difficulties with previous dental treatment? ☐ Yes ☐ No If yes please explain: _____

_____

_____

What type of water do you drink? (check all that apply)
☐ City ☐ Well ☐ Bottled ☐ Filtered

Does your child participate in physical recreational activities?
☐ Yes ☐ No

If you have dental insurance, do you let the insurance dictate what treatment your child should receive? ☐ Yes ☐ No

Do you have suggestions on how Pine Ridge Dental can best meet your needs? ☐ Yes ☐ No If yes please explain: _____

_____

_____

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.

Patient signature:_____ Date:_____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY Doctor's Comments:

_____

_____

_____

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Insurance, Financial Options, and Appointment Agreement

Patient Name:	Date of Birth:

Dental Insurance

As a courtesy, we will process insurance for you. All questions regarding your insurance coverage must be addressed by you with your insurance company. **We will try to help you understand your insurance coverage, but ultimately it is your responsibility to know the details of your plan**. Insurance companies never guarantee benefits.

Dental insurance is a contract between the employer and the patient. For example, Amalgam verses Composite for fillings. The extent of coverage varies greatly between plans and sometimes even within a single plan. We will always recommend optimal treatment according to our standard of care regardless of insurance coverage. *(Initial)* _____

Any balance not covered by your dental insurance is your responsibility. The estimated portion will be due at the time of treatment, unless prior arrangements have been made. Should our estimation be too high, a refund will be made. Likewise, if the estimate was too low, the remainder will be your responsibility. *(Initial)* _____

Primary Insurance Coverage		Secondary Insurance Coverage	
Policy Holder: _____		Policy Holder: _____	
Employer: _____		Employer: _____	
Insurance Company: _____		Insurance Company: _____	
Claims Address: _____		Claims Address: _____	
City, State, Zip: _____		City, State, Zip: _____	
Phone: _____	Group #: _____	Phone: _____	Group #: _____
Policy Holder ID #: _____	Date of Birth: _____	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 payment options:
- Patients **without insurance** coverage can receive <u>one</u> of the following:
  - 5% discount when services are **paid in full with cash or check the day of treatment**
  - 10% discount for senior citizens and military personnel
  - Patients also have the opportunity to utilize our "On Call Club" discount for recall appointments.
- Visa, MasterCard, Discover, Cash, Check
- 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. I understand that all payments are due within 60 days of the date of service. I understand that at 60 days my account will accrue interest 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

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Patient Acknowledgment of Receipt of Notice of Privacy Practices

HIPAA Authorization

I hereby acknowledge that I have reviewed and received a copy of Pine Ridge Dental's *Notice of Privacy Practices* explaining:

- How Pine Ridge Dental will use and disclose my protected health information,
- My privacy rights with regard to my protected health information, and
- Pine Ridge Dental's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or concerns, I may contact Colene at 402-423-1100 or colene@pineridgedental.com.

I may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Their contact information can be found at www.hhs.gov/about/contactus/index.html.

I hereby give authorization to the following people to access my personal health information:

_____ _____ _____

Consent for Communications

I give consent to the dental practice to use my cell phone number regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My cell phone is (____) _____. I consent to *(Choose one or both):* ☐ Call ☐ Text

I give consent to receiving emails from the dental practice regarding treatment, insurance, special promotions, and my account. I understand I can withdraw my consent at any time.

My email address is _____.

_____ _____
Patient / Parent / Legal Guardian Signature Date

FOR OFFICE USE ONLY

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) _____
☐ Communication barriers prohibited obtaining an acknowledgment
☐ An emergency situation prevented us from obtaining an acknowledgment
☐ Other _____

Attempt was made by: _____ Date: _____