Heidi J. Stark, D.D.S.
Diplomate, American Board of Pediatric Dentistry

Libby A. Johnson, D.D.S.
Diplomate, American Board of Pediatric Dentistry

Emily J. Egley, D.D.S.
Diplomate, American Board of Pediatric Dentistry

Katie J. Garcia, D.D.S.
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LINCOLN PEDIATRIC DENTISTRY

Thank you for selecting Lincoln Pediatric Dentistry for your child's dental care!

- Your child's initial appointment will take approximately 40-60 minutes. Please arrive 15 minutes early in order to process your child's health and insurance information.

- Please complete the Patient's Registration and History form prior to arriving at our office. If possible, mail or fax the paperwork to us ahead of time. If you don't have an opportunity to mail or fax it to us, please bring your completed paperwork to your appointment.

- To see what your child's first visit will be like, visit our website at www.lincolnpediatricdentistry.com. Go to the Dental Information tab, select Exams, click on Comprehensive Exam, "Watch this video to see what to expect at your child's first visit" – *"Click Here"*.

- Every effort is made to schedule a time that will work for you. If you are unable to keep this appointment, we require at least 24 hours advance notice. If no notice is given and you have missed the appointment, you will not be allowed to reschedule.

- If you are 10 minutes late for any appointment, we will try to accommodate you if our schedule allows. However, if that isn't possible we may ask that you reschedule for another day or time.

- If there is a language barrier, please bring an interpreter in order to understand your child's treatment and any financial obligations.

For additional information on our dentists, to meet the team, take an office tour, and our financial policy, please read the practice brochure or visit our website.

North Office:
3272 Salt Creek Circle,
Suite A
Lincoln, NE 68504
ph. 402-476-1500
fx. 402-476-1510

Southeast Office:
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LincolnPediatricDentistry.com

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Patient's Registration And History

In order to provide the best and safest comprehensive dental care for your child we are thanking you in advance for completing our detailed medical history form.
Please print in blue or black ink.

Child's Name _____ Preferred Name _____
First MI Last

Birthdate _____ Age _____ SS# _____ Gender M F

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Primary Language Spoken _____

Child primarily lives with (check all that apply): ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather
☐ Grandparent ☐ Foster parent/guardian ☐ other _____

Please check YES or NO as it applies to your child:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	ADD/ADHD	☐	☐	Brain Injury	☐	☐	Epilepsy/Seizures	☐	☐	MRSA
☐	☐	Adopted	☐	☐	Cerebral Palsy	☐	☐	Eye Conditions	☐	☐	MSPI
☐	☐	AIDS/HIV	☐	☐	Chemical Dependence	☐	☐	Hearing Impairment	☐	☐	Pregnancy (Patient)
☐	☐	Allergy to Augmentin	☐	☐	Chemo/Radiation	☐	☐	Heart Disease/Cond	☐	☐	Premature Birth
☐	☐	Allergy to Latex	☐	☐	Chicken Pox	☐	☐	Heart Murmur	☐	☐	Psychiatric Care
☐	☐	Allergy to Peanuts	☐	☐	Child Abuse		☐	Innocent Heart Murmur	☐	☐	Juvenile Rheumatoid Arthritis
☐	☐	Allergy-Omnicef/Ceph	☐	☐	Cleft Palate/Lip		☐	Due to Heart Condition	☐	☐	Shunts
☐	☐	Allergy to Pen/Amox	☐	☐	Cold/Canker Sores		☐	SBE/Antibiotic required			Explain _____
☐	☐	Allergy-Seasonal	☐	☐	Depression	☐	☐	Hemophilia	☐	☐	Sickle Cell Disease
☐	☐	Allergy-Sulfa Meds	☐	☐	Developmental Delay	☐	☐	Hepatitis	☐	☐	Sickle Cell Trait
☐	☐	Asthma		☐	Motor	☐	☐	High Blood Pressure	☐	☐	Speech Impairment
☐	☐	Autism/Asperger's		☐	Speech	☐	☐	Injury - Front Teeth	☐	☐	Thyroid Disease
☐	☐	Behavioral Problems		☐	Cognitive	☐	☐	Kidney Disease	☐	☐	Tonsilitis
☐	☐	Birth Defects	☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Blood Transfusions	☐	☐	Down Syndrome	☐	☐	Lung Disease	☐	☐	Tumor, Cancer
☐	☐	Bone/Joint Problems	☐	☐	Earaches/Ear Infections	☐	☐	Metal Implant/Pins/Rods	☐	☐	Wheelchair

Child's Medical Doctor _____ Phone: _____ Date of last exam _____

Is your child presently under the care of a physician or specialist for any reason? ☐ YES ☐ NO
Explain _____
Doctor Name _____ Phone _____

Is your child taking any medications? ☐ YES ☐ NO
List _____

Does your child have any allergies to medicines, latex, foods, or metals not listed above? ☐ YES ☐ NO
List _____

Are antibiotics necessary prior to dental work because of a heart murmur,defect,prosthesis,shunt,or other medical reason? ☐ YES ☐ NO
Explain _____

Has your child been hospitalized,sedated,or had surgery? ☐ YES ☐ NO
Explain _____

Has any member of the family,including your child,had a problem with sedation or general anesthesia? ☐ YES ☐ NO
Explain _____

Are your child's immunizations up to date? ☐ YES ☐ NO

Is there any other health information that should be known? ☐ YES ☐ NO
Explain _____

Dental History

Is this your child's first dental visit? ☐ YES ☐ NO Previous Dentist _____

Date of Last Visit _____ Date of Last X-rays_____

Is your child seeing an orthodontist? ☐ YES ☐ NO If yes, name _____

How often does your child brush? _____

Is tooth brushing supervised? ☐ YES ☐ NO Is dental floss used? ☐ YES ☐ NO

Does your child receive (check all that apply):

☐ Fluoride in vitamins ☐ Bottled water ☐ Fluoridated tap water ☐ Fluoride tablets/drops

☐ Non-fluoridated tap water ☐ Well water ☐ Vitamins [☐ chewable ☐ gummy ☐ liquid]

Any injuries to your child's teeth or jaws? ☐ YES ☐ NO

Explain _____

History of (check all that apply):

☐ Currently Breastfeeding ☐ Breastfed in past ☐ Thumb sucking ☐ Bottle habits

☐ Pacifier ☐ Sippy cup ☐ Teeth grinding/clinching

Has your child experienced any unfavorable reaction from previous dental or medical care? ☐ YES ☐ NO

Explain _____

How do you think your child will act toward the dentist? _____

Has your child had recent dental pain or have a specific dental problem that needs special attention? ☐ YES ☐ NO

Explain _____

Do you have any questions for our staff prior to your child's visit today? ☐ YES ☐ NO

Consent

The permission of a parent or guardian is necessary for dental treatment of a minor.

As parent or guardian of the above patient, I authorize and request the performance of dental services for this patient by Dr. Stark, Dr. Johnson, Dr. Egley, Dr. Garcia and their staff, as may be designated. I understand that Dr. Stark, Dr. Johnson, Dr. Egley, Dr. Garcia and their staff will use digital radiographs (xrays), diagnostic, and patient management techniques that are reasonable, necessary, and advisable. I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition. I agree to inform Dr. Stark, Dr. Johnson, Dr. Egley, Dr. Garcia and their staff of any changes in the medical history. This authorization is valid until revoked in writing.

Financial Authorization

Please indicate the manner you wish to handle your account.

☐ I have no dental insurance. I will pay cash, check, VISA, MasterCard or Discover the day of the appointment with a 5% courtesy discount.

☐ I have dental insurance and will pay my estimated portion of the total charges on the day of the appointment.

☐ I have Medicaid coverage.

☐ I will pay with 3rd party financing through Care Credit.

I accept financial responsibility for this child. I authorize the release of any dental information necessary to process this claim and all future claims. I authorize insurance payments directly to Lincoln Pediatric Dentistry. I fully understand I am solely responsible for any balance not paid by the insurance company. I will be responsible for reporting any changes in my child's dental insurance coverage. I will be responsible for any late fees due on my account.

Signature _____Relationship to child_____ Date_____

Parent or Guardian Information

Name _____ Gender M F
First MIddle Last Relationship to Patient

☐ Married ☐ Single ☐ Other Birthdate _____ SS# _____

Address _____

City _____ State _____ Zip Code _____

Email _____ Cell Phone _____

Home Phone _____ Work Phone _____ Extension _____

Employer _____ Occupation _____

Name _____ Gender M F
First MIddle Last Relationship to Patient

☐ Married ☐ Single ☐ Other Birthdate _____ SS# _____

Address _____

City _____ State _____ Zip Code _____

Email _____ Cell Phone _____

Home Phone _____ Work Phone _____ Extension _____

Employer _____ Occupation _____

Emergency Contact Information (not parent/guardian)

Name _____ Relationship to child _____

Address _____ Phone _____

Primary Dental Insurance

Insured's Name _____

Insurance Company _____

Insurance Phone _____

Employer Name _____ Employer Phone _____

Employer Address _____

Secondary Dental Insurance

Insured's Name _____

Insurance Company _____

Insurance Phone _____

Employer Name _____ Employer Phone _____

Employer Address _____

Medicaid Insurance

Patient's Name _____ I.D.# _____

Because referrals are important to us, who may we thank for referring you to our office?

☐ Family ☐ Friend ☐ Doctor ☐ Dentist

Name _____ Phone _____

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HIPAA Acknowledgement And Consent, Limited Authorization And Release Form

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

☐ By providing email addresses and cell phone numbers, I agree to be contacted via email and text message to confirm/schedule appointments and receive billing statements. Additional methods may include: home phone, work phone, and any voicemail. If none of these methods are available, I understand that paper copies may be mailed to my home address.

☐ I agree that my child's health information may be conveyed electronically to any person involved in his/her medical/dental care, for payment of his/her care and submitting insurance/billing information.

PLEASE LIST ANY PARTIES OTHER THAN THE PARENT OR GUARDIAN WHO CAN BRING YOUR CHILD(REN) TO THEIR APPOINTMENTS AND CAN HAVE ACCESS TO THEIR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

The undersigned acknowledges receipt or understanding of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

****MY SIGNATURE WILL ALSO SERVE AS A PUBLIC HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE****

_____ _____

Please ***print*** name of Parent or Guardian | Please ***print*** name of Patient(s)

_____ _____ Date: _____

Signature of Parent/Guardian | Relationship to Patient

Office Use Only

We attempted to obtain the parent/guardian's signature on this Acknowledgement but did not because:

An emergency situation prevented consent _____

Communication barrier with the patient _____

Individual refused to sign _____

Other (please describe) _____ _____

Signature of Lincoln Pediatric Dentistry Staff

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Southeast Location: 4301 S. 80th St. • Lincoln, NE 68516 • Phone (402) 476-4301 • Fax (402) 476-4305
www.lincolnpediatricdentistry.com

HEIDI J. STARK, D.D.S.

Diplomate, American Board of Pediatric Dentistry

I am a native of Lincoln and received my Doctor of Dental Surgery degree from the UNMC College of Dentistry. I completed my Pediatric Dental Residency at Children's Hospital of Northwestern University in Chicago. I have been elected a Fellow of the International College of Dentists and American College of Dentists. I served as a board member for the Lincoln Lancaster County Health Department. I am on health advisory committees for Excite and Headstart.

LIBBY A. JOHNSON, D.D.S.

Diplomate, American Board of Pediatric Dentistry

I grew up in Sioux Falls, South Dakota and knew early on that I wanted to attend UNL and be a Husker! I attended dental school at the UNMC College of Dentistry where I received my Doctor of Dental Surgery degree. I finished my Pediatric Dental Residency program at UNMC in Omaha. I served as a delegate for the Nebraska Dental Association.

EMILY J. EGLEY, D.D.S.

Diplomate, American Board of Pediatric Dentistry

I am originally from Blue Springs, Missouri, and came to Lincoln to attend UNL. I graduated with my Doctor of Dental Surgery degree from the UNMC College of Dentistry and then completed my Pediatric Dental Residency at UNMC in Omaha. I serve as a delegate for the Nebraska Dental Association.

KATIE GARCIA, D.D.S.

Diplomate, American Board of Pediatric Dentistry

I grew up in Lincoln and graduated from UNL. I received my Doctor of Dental Surgery degree from the UNMC College of Dentistry. I completed a General Practice Residency at Peninsula Hospital in Queens, New York, and then a Pediatric Dental Residency at Children's Hospital of Northwestern University in Chicago. I am president elect of the Lincoln District Dental Association.

*All four dentists are members of the American Academy of Pediatric Dentistry, American Dental Association, Lincoln District Dental Association, and Nebraska Dental Association. Each one volunteers at Clinic with a Heart and other community organizations.

For more information about our doctors, visit www.lincolnpediatricdentistry.com!

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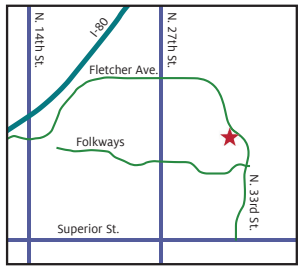
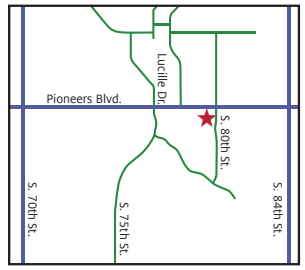
NORTH LOCATION – 3272 SALT CREEK CIR., SUITE A

SOUTHEAST LOCATION – 4301 S. 80TH ST.





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WE MAKE BEAUTIFUL SMILES

LINCOLN PEDIATRIC DENTISTRY

WELCOME TO OUR PRACTICE

We are pleased that you have chosen our office to provide dental care for your child. Our goal is to help your child achieve a healthy smile and remain cavity free. We want to educate you and your child so that he/she will grow up having a positive dental experience that can be passed on to family and friends.

Our office is specially designed to treat infants, children, teenagers, and patients with special needs. You will find that our staff is trained to understand the concerns and needs of children and their parents. We want your child to leave our office feeling good about the experience and understanding the importance of good oral hygiene. We are confident you will find Dr. Heidi, Dr. Libby, Dr. Emily, Dr. Katie and our staff to be caring, competent, and gentle. We are always willing to answer any of your questions or concerns.

TIPS FOR A POSITIVE DENTAL EXPERIENCE

- **Schedule 1st visit by age 1.**
- **Schedule morning appointments for young children, when they tend to be rested and cooperative.**
- **Use simple and positive words.**
- **Never use the dentist as a threat.**
- **Please keep your anxiety to yourself.**
- **Do not bribe your child to come to the dentist.**

WHAT TO EXPECT AT YOUR CHILD`S FIRST VISIT

Your child's first dental visit will include a medical history review and a thorough dental exam. The dental exam will be an evaluation of the teeth and gums, a head and neck exam, and a preliminary orthodontic evaluation.

Your child will receive a cleaning and fluoride treatment. Digital x-rays may be taken based on the child's needs. Our dentists will develop a diagnosis and treatment plan and will discuss the findings with you at the end of the appointment.

We find by age 3 most children like to come back to the treatment area by themselves and enjoy their independence. We encourage this, as we continue to develop a relationship with your child. We spend time talking with them and showing them photos of cavities, plaque, dental floss and healthy teeth. We also teach them how to brush with adult supervision at our child size brushing stations.

FINANCIAL POLICY

Payment is due at the time dental services are provided. As a courtesy, we will bill your insurance company for their portion. We accept cash, checks, Visa, MasterCard or Discover.

An alternative, CitiHealth, is a healthcare credit system which allows interest free payments for up to one year. Applications are available online at www.healthcard.citicards.com, or from our financial coordinator.

Our office is in network with Aetna, Ameritas, Blue Cross Blue Shield, Delta Dental, Metlife, Principal, Standard, and United Concordia dental insurances.

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