LINCOLN PEDIATRIC DENTISTRY

HEIDI J. STARK, DDS.
Diplomate, American Board of Pediatric Dentistry
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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 home

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-Explain _____
☐	☐	Allergy to Pen/Amox	☐	☐	Cold/Canker Sores		☐	SBE/Antibiotic required	☐	☐	Sickle Cell Disease
☐	☐	Allergy-Seasonal	☐	☐	Depression	☐	☐	Hemophilia	☐	☐	Sickle Cell Trait
☐	☐	Allergy-Sulfa Meds	☐	☐	Developmental Delay	☐	☐	Hepatitis	☐	☐	Speech Impairment
☐	☐	Asthma		☐	Motor	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease
☐	☐	Autism/Asperger's		☐	Speech	☐	☐	Injury - Front Teeth	☐	☐	Tonsilitis
☐	☐	Behavioral Problems		☐	Cognitive	☐	☐	Kidney Disease	☐	☐	Tuberculosis
☐	☐	Birth Defects	☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Tumor, Cancer
☐	☐	Blood Transfusions	☐	☐	Down Syndrome	☐	☐	Lung Disease	☐	☐	Wheelchair
☐	☐	Bone/Joint Problems	☐	☐	Earaches/Ear Infections	☐	☐	Metal Implant/Pins/Rods			

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_____

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 CitiHealth or 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

North Location: 3272 Salt Creek Circle, Ste. A • Lincoln, NE 68504 • Phone (402) 476-1500 • Fax (402) 476-1510
Southeast Location: 4301 S. 80th St. • Lincoln, NE 68516 • Phone (402) 476-4301 • Fax (402) 476-4305
www.lincolnpediatricdentistry.com