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.
Diplomate, American Board of Pediatric Dentistry

Allie L. Wolf, D.D.S.

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.

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

Southeast Office:
4301 S. 80th St.
Lincoln, NE 68516
ph. 402-476-4301
fx. 402-476-4305

East Office:
7001 A St., #103
Lincoln, NE 68510
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fx. 402-434-3368

LincolnPediatricDentistry.com

LINCOLN PEDIATRIC DENTISTRY

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

Primary Language Spoken _____

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

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 _____

Parent or Guardian Information

Name _____ Gender ☐M ☐F
First MI 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 MI Last Relationship to Patient

☐ Married ☐ Single ☐ Other Birthdate _____ SS# _____

Address ☐ Same as above _____

City _____ State _____ Zip Code _____

Email _____ Cell Phone _____

Home Phone _____ Work Phone _____ Extension _____

Employer _____ Occupation _____

Emergency Contact Information (not parent/guardian)

Name _____ Relationship to child _____ Phone _____

Primary Dental Insurance

Insured's Name _____

Insurance Company _____

Insurance Phone _____

ID # _____

Group/Policy # _____

Secondary Dental Insurance

Insured's Name _____

Insurance Company _____

Insurance Phone _____

ID # _____

Group/Policy # _____

Allergy and Reaction – Please check all that apply to your child:

Medication Allergy **Reaction:**

- ☐ Acetaminophen: _____
- ☐ Albuterol: _____
- ☐ Augmentin: _____
- ☐ Azithroymcin: _____
- ☐ Bactrim: _____
- ☐ Cefdinir: _____
- ☐ Cefuroxime: _____
- ☐ Ciprofloxacin: _____
- ☐ Codeine: _____
- ☐ Ibuprofen: _____

Medication Allergy **Reaction:**

- ☐ Neosporin: _____
- ☐ Omnicef/Ceph: _____
- ☐ Pen/Amox: _____
- ☐ Sulfa Meds: _____
- ☐ Other Med Allergy-List: _____

_____

General Allergy **Reaction:**

- ☐ Animal-List: _____
- ☐ Bandaids: _____
- ☐ Dye(s)-List: _____

General Allergy **Reaction:**

- ☐ Flu shot: _____
- ☐ Food-List: _____
  - ☐ Lactose Intolerance: _____
  - ☐ MSPI: _____
  - ☐ Nut-List: _____
  - ☐ Peanut: _____
- ☐ Latex: _____
- ☐ Metal(s): _____
- ☐ Mold: _____
- ☐ Seasonal-Meds taken: _____

_____

- ☐ Other Allergy-List: _____
- ☐ EpiPen Required-Reason: _____

Health History and Medications – Please check all that apply to your child:

Heart **Medication**

- ☐ Heart disease/condition: _____
- ☐ Heart murmur
  - ☐ Innocent Heart Murmur
  - ☐ Due to Heart Condition
  - ☐ SBE/Antibiotic required

Respiratory **Medication**

- ☐ Asthma: _____
- ☐ Other: _____

Gastro-Intestinal **Medication**

- ☐ Acid Reflux: _____
- ☐ Celiac disease: _____
- ☐ G-Button/Tube

Neurology **Medication**

- ☐ Brain injury-Explain: _____
- ☐ Cerebral palsy: _____
- ☐ Epilepsy/Seizures: _____
- ☐ Shunts-Explain: _____

Endocrine **Medication**

- ☐ Diabetes-Type: _____
- ☐ Thyroid Disease: _____

Hematology **Medication**

- ☐ Blood Disorder-Type: _____
- ☐ Blood Transfusions-Explain: _____

_____

- ☐ Hemophilia: _____
- ☐ Kidney Disease: _____
- ☐ Leukemia: _____
- ☐ Liver Disease: _____
- ☐ Sickle Cell Disease: _____
- ☐ Sickle Cell Trait: _____

Behavioral/Development **Medication**

- ☐ ADD/ADHD: _____
- ☐ Anxiety: _____
- ☐ Autism/Aspergers: _____
- ☐ Behavioral problems: _____
- ☐ Depression: _____
- ☐ Developmental Delay
  - ☐ Motor
  - ☐ Speech
  - ☐ Cognitive
- ☐ Psychiatric care-Explain: _____
- ☐ Sensory Issues-Explain: _____
- ☐ Speech Impairment

Infectious Disease **Medication**

- ☐ AIDS/HIV: _____
- ☐ Chicken Pox
- ☐ Hepatitis: _____
- ☐ MRSA
- ☐ Tuberculosis: _____

Musculoskeletal **Medication**

- ☐ Bone/joint Problems: _____
- ☐ Juvenile RA: _____
- ☐ Metal implants/pins/rods-Explain: _____

_____

- ☐ Muscular Dystrophy: _____

Other

- ☐ Adoption-Date: _____
- ☐ Child Abuse-Explain: _____

_____

- ☐ GA/Sedation Issue
  - ☐ Family-Explain: _____
  - ☐ Patient: _____
- ☐ Wheelchair

General **Medication**

- ☐ Birth Control: _____
- ☐ Birth defects-Explain: _____
- ☐ Chemical dependence
- ☐ Cleft Palate/Lip-Surgeries: _____
  - ☐ Cranialfacial Team
- ☐ Cold/Canker Sores: _____
- ☐ Down Syndrome
- ☐ Ear/Nose/Throat
  - ☐ Adenoidectomy-Date: _____
  - ☐ Ear Tubes-Date: _____
  - ☐ Tonsilectomy-Date: _____
  - ☐ Other: _____
- ☐ Eye Conditions
- ☐ Failure to Thrive
- ☐ Hearing Impairment
- ☐ Pregnancy (Patient)
- ☐ Premature Birth
- ☐ Skin Condition
  - ☐ Acne: _____
  - ☐ Eczema: _____
  - ☐ Vitiligo
- ☐ Tumor-Type: _____
- ☐ Cancer-Type: _____
- ☐ Chemo/Radiation: _____
- ☐ Vitamins: _____
  - ☐ Chewable
  - ☐ Gummy
  - ☐ Liquid
  - ☐ Pill

Immunizations up to date: Yes ☐ No ☐

If No-Reason: _____

- ☐ Antibiotic Premed Required-Reason:

_____

_____

Other Health Condition-List: _____

_____

Other Medications-List: _____

Hospitalization/sedation/surgery-Explain: _____

_____

Further Explanation: _____

_____

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

Any injuries to your child's teeth or jaw? ☐ YES ☐ NO Explain _____

Patient History of (check all that apply): ☐ Currently Breastfeeding ☐ Breastfed in past ☐ Thumb sucking ☐ Bottle habits ☐ Pacifier

☐ Sippy cup ☐ Teeth grinding/clinching ☐ Frenectomy ☐ Dental Surgery-Explain: _____

_____

Family History of (check all that apply): ☐ Missing Teeth ☐ Impacted Canines ☐ Other: _____

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, Dr. Wolf and their staff, as may be designated. I understand that Dr. Stark, Dr. Johnson, Dr. Egley, Dr. Garcia, Dr. Wolf 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, Dr. Wolf 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/MCNA 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_____

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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EMILY J. EGLEY, DDS
Diplomate, American Board of Pediatric Dentistry
KATIE J. GARCIA, DDS
Diplomate, American Board of Pediatric Dentistry
ALLIE L. WOLF, DDS

HIPAA Acknowledgement And Consent, Limited Authorization And Release Form

☐ 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.

☐ I understand if I send information or pictures of my child via text/email directly to a doctor or to Lincoln Pediatric Dentistry it is not encrypted, unless I have used an application to encrypt the text/email.

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 stepparents, grandparents and any caretakers who can have access to this patient's records.) MUST BE 19 Y.O. OR OLDER.

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

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

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 • 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
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