Child Patient Form

Nebraska Dental Center

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Date: ____

Patient's Last Name: ________________________ First: ____________________ Middle: ____________

Preferred Name *(if different):* ________________________ ☐ Male ☐ Female Date of Birth: ______________

Hobbies/Interests: ______________________________ School: ____________________ Grade: ____

Parent's Name(s): ______________________________ Home Phone: ________________________

Father's Employer: ____

Business Address: ______________________ City: __________________ State: ______ Zip: __________

Business Phone: ______________________________ Occupation: ________________________

Mother's Employer: ____

Business Address: ______________________ City: __________________ State: ______ Zip: __________

Business Phone: ____

Whom may we thank for referring you to our practice? ____

Primary Insurance Information

Insured's Name ____ Is the insured our patient? ☐ Yes ☐ No

Last, First, Middle

Insured's Birth Date: __________________ ID#: ____________________ Group #: ____________________

Address: ______________________ City: ____________________ State: ________ Zip: __________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________________________

Insured's Employer's Name: ____

Address: ______________________ City: ____________________ State: ________ Zip: __________

Insurance Plan Name: ______________________________ Address: ______________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services performed without previous financial arrangements, must be paid for in cash at the time the services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and further agree to pay all costs and reasonable attorney fee if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Patient's Signature ______________________________ *Printed Name* ______________________________

Date: ______________________________ *Relationship to Patient:* ______________________________

Patient's Last Name: ______________________________ First: ________________________ Middle: ____________

Health Information

Does your child have any immediate dental problems? ☐ No ☐ Yes

If yes, please describe: ____

Date of last dental visit:____________________ What was done for your child at that time? _______________________

____

Has your child ever had any of the following? *(Check all that apply.)*

☐ Rheumatic Fever	☐ Epilepsy or Seizures	☐ Hay Fever	☐ Radiation Treatment
☐ Heart Murmur	☐ Anemia	☐ Head Injuries	☐ Respiratory Problems
☐ Heart Disease	☐ Asthma	☐ Hepatitis	☐ Penicillin Allergy
☐ Abnormal Bleeding	☐ Dizziness	☐ Jaundice	

☐ Allergies ____

☐ Other ____

Is your child allergic to any medications or latex? ☐ No ☐ Yes If yes, what: ___________________________________

Describe your child's general health: ☐ Excellent ☐ Good. ☐ Fair ☐ Poor

Does your child have any fear of medical or dental offices? ☐ No ☐ Yes

Is your child presently taking any medications? ☐ No ☐ Yes

If yes, please specify: ____

Is your child currently under the care of a physician? ☐ No ☐ Yes If yes, physician's name:_______________________

Please explain:____

Does your child have any health problems that need further clarification? ☐ No ☐ Yes

Please explain:____

Please provide any additional information that may help us care for your child:_______________________________

____

To the best of my knowledge, all information provided is true and accurate. If my child ever has any change in his/her health, I will inform the Nebraska Dental Center, P.C. at the next appointment without fail.

____ Date:_______________________________

Parent/Guardian's signature

Medical Updates

Date	*Exceptions*	*Signature*	*Reviewed By*
__________	________________________ ___________________ ☐ None	____________________	________________
__________	________________________ ___________________ ☐ None	____________________	________________
__________	________________________ ___________________ ☐ None	____________________	________________
__________	________________________ ___________________ ☐ None	____________________	________________