



Helping every child have a happy, healthy smile...

PEDIATRIC DENTAL SPECIALISTS OF GREATER NEBRASKA

Edward H. Lockwood, D.D.S., M.S. Jessica A. Meeske, D.D.S., M.S. Holly A. Portwood, D.D.S.

P.O. Box 667 • Dentistry for Children & Adolescents Hastings, Nebraska 68902-0667 • Telephone 402-462-6557

CHILD'S REGISTRATION AND HISTORY

GET-ACQUAINTED QUESTIONNAIRE

TODAY'S DATE _____

I. SOCIAL HISTORY (Please use different colors of ink for annual updates).

CHILD'S NAME _____ Nickname _____ SSN # _____

Sex Male Female Age _____ Birthdate _____

Attends what school _____ Grade _____

Names and ages of brothers and sisters _____

Please tell us the names of your other children that have been patients in this office _____

FATHER _____ SSN # _____ Home Phone _____

Email Address _____ Message Phone _____

Address _____ Birthdate: _____ Cell Phone _____

City _____ State _____ Zip _____

Employed By _____ How Long? _____ Business Phone _____

MOTHER _____ SSN # _____ Home Phone _____

Email Address _____ Message Phone _____

Address _____ Birthdate: _____ Cell Phone _____

City _____ State _____ Zip _____

Employed By _____ How Long? _____ Business Phone _____

*Please provide a friend or relative who can be contacted in case of emergency Name _____ Phone _____

Parents: Married Single Divorced Child Lives With: _____

Who is responsible for making appointments? NAME _____

Who referred you to this office? _____

I acknowledge that Pediatric Dental Specialists of Greater Nebraska has presented and made available to me their "Notice of Privacy Practices" for protected health information. X _____

I authorize Pediatric Dental Specialists of Greater Nebraska to use and disclose my Protected Health Information for treatment, payment and healthcare operations. X _____

The policy of our office requires one of the following arrangements for payment of fee.

Please check your preference:

- 1. Cash payable at the time of each office visit. 2. Care Credit/Patient Payment Plans 3. Visa or MasterCard, payable at the time of each office visit. 4. Child currently covered by Medicaid or Kid's Connections.

We will be glad to process any insurance claim forms upon request. However, financial responsibility on all accounts rests solely with the parents or guardian with legal custody of the child.

INSURANCE: Complete Backside

INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ___ / ___ / ___ & SS #: _____

Insured's Employer: _____

Orthodontic Coverage? Yes No

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthday: ___ / ___ / ___ & SS #: _____

Insured's Employer: _____

Orthodontic Coverage? Yes No

I authorize release of any information relating to this claim.

X

Signed (Patient, or Parent if Minor)

Date

I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

X

Signed (Insured Person)

Date

Above Information Complete By: **X**

DENTAL AND ACCIDENT INSURANCE

It is important for you to be informed that if you are covered by Dental or Accident Insurance, our professional services are rendered and charged to you, *not* to the insurance company. Our services are offered on the basis that full charges will be paid by you. Most insurance coverage only pays a portion of the cost of such services that may be necessary.

You will be assisted in preparing necessary forms for your insurance claims as a courtesy. It may be necessary for you to provide the forms. You can obtain forms from your insurance company or union.

Some health insurance programs provide limited coverage for oral surgery and orthodontics. Some provide no coverage. Very few pay the entire charge. Please note our diagnosis and treatment plans are based on what's in the best interests of your child as opposed to what a particular insurance plan may cover or not cover. Because we file claims on families' behalf to over 50 different companies, we urge you to be fully aware of the provisions of your policy.

Thank you.

If English is a second language in the home of this child:

Being able to effectively communicate with a child's parent/guardian is important in providing safe and optimal dental care. If you have difficulty understanding and/or speaking English, we request that you **bring a translator to each dental visit**. Please provide us with a name of a friend or family member who can speak fluent English in the case that we are unable to communicate with the parent:

Name _____ Phone _____