Nebraska Dental Center

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Date: _____

Patient's Last Name: _____ First: _____ Middle: _____

Preferred Name *(if different)*: _____ ☐ Male ☐ Female ☐ Married ☐ Single

Social Security #: _____ Date of Birth: _____

Phone Home: _____ Business: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Hobbies/Special Interests _____

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 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

Do you have any immediate dental problems? ☐ No ☐ Yes

If yes, please describe: _____

Date of last dental visit:_____ What was done for you at that time? _____

_____

Have you ever had any of the following? *(Check all that apply.)*

☐ AIDS or HIV+	☐ Epilepsy	☐ Kidney Disease	☐ Respiratory Problems
☐ Artificial Joints	☐ Excessive Bleeding	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Head Injury	☐ Osteoporosis	☐ Smoking
☐ Cancer	☐ Heart Attack	☐ Nervous Disorder	☐ Steroid Therapy
☐ Chemotherapy	☐ Heart Disease	☐ Pacemaker	☐ Stroke
☐ Diabetes	☐ Hepatitis	☐ Pregnancy	☐ Tuberculosis
☐ Emphysema	☐ High Blood Pressure	☐ Radiation Treatment	☐ Venereal Disease

☐ Other _____

Are you currently pregnant? ☐ No ☐ Yes Due date:_____

Are you allergic to any medications or latex? ☐ No ☐ Yes If yes, what: _____

Medications currently taking: _____

_____

Check any medications you have taken for osteoporosis or cancer chemotherapy:
☐ Fosamax ☐ Actonel ☐ Boniva ☐ Zometa ☐ Aredia ☐ Reclast ☐ Prolia ☐ Other: _____

Have you ever had any complications following dental treatment? ☐ No ☐ Yes

If yes, please explain: _____

In the past two years have you been admitted to a hospital or needed emergency care? ☐ No ☐ Yes

If yes, please explain: _____

Are you under the care of a physician? ☐ No ☐ Yes If yes, physician's name _____

Please explain:_____

Do you have any health problems that need further clarification? ☐ No ☐ Yes

If yes, please explain: _____

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

_____ Date: _____

Patient's signature (or parent/guardian if under 19)

Medical Updates

Date	*Exceptions*	*Signature*	*Reviewed By*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____