New Patient Questionnaire

Children's
Dentistry of Lincoln
Tom J. Milius, D.D.S.

1140 North 83rd St. • Lincoln, NE 68505

Today's Date _____

Child's Name _____

Preferred Name _____ Age _____ Date of Birth _____

Sex: ❑ Male ❑ Female

SS# _____ Attends what school _____ Grade _____

Names and ages of brothers and sisters _____

Father _____ SS # _____

Date of Birth _____ Home phone _____ Cell phone _____

Residence _____ City _____ State _____ Zip _____

Employed by _____ Business Phone _____

Employer address _____

Mother _____ SS # _____

_

Date of Birth _____ Home phone _____ Cell phone _____

Residence _____ City _____ State _____ Zip _____

Employed by _____ Business Phone _____

Employer address _____

Parents are: ❑ Married ❑ Single ❑ Divorced - Child lives with: _____

Email Address of ❑ Mother or ❑ Father: _____

Who is responsible for making appointments? Name _____

Emergency Contact Information (not parent/guardian)

Name _____ Relationship to child _____

Address _____

Phone _____

Primary Dental Insurance

Insured's Name _____ Subscriber ID # _____

Insurance Company _____

Insurance Phone _____

Employer Name _____ Employer Phone _____

Employer Address _____

Secondary Dental Insurance

Insured's Name _____ Subscriber ID # _____

Insurance Company _____

Insurance Phone _____

Employer Name _____ Employer Phone _____

Employer Address _____

Medicaid Insurance

Patient's Name _____ ID # _____

Because referrals are important to us, who may we thank for referring you to our office?

_____ Family _____ Friend _____ Doctor _____ Dentist _____ Other

Name _____ Phone _____

Financial Authorization

Please indicate the manner you wish to handle your account.

- ❑ I have no dental insurance. I will pay cash or check the day of the appointment with a 5% courtesy discount.
- ❑ I have no dental insurance. I will pay with VISA or MasterCard.
- ❑ 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 would like to discuss 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 Children's Dentistry of Lincoln. 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

Child Health/Dental History Questions

Has the child had any history of, or conditions related to, any of the following (if not listed, please explain):

❑ Anemia	❑ Cancer	❑ Growth Problems	❑ Latex Allergy	❑ Psychiatric Treatment
❑ Asthma	❑ Cerebral Palsy	❑ Hearing Impairment	❑ Liver Disease	❑ Recurrent Headaches
❑ Attention Deficit	❑ Cleft Lip/Palate	❑ Heart/Heart Defect	❑ Lung Disease	❑ Rheumatic Fever
❑ Autism	❑ Diabetes	❑ Hemophilia	❑ MRSA	❑ Seizures
❑ Bladder/Kidney	❑ Eye Disorders	❑ Hepatitis	❑ Muscle Disorders	❑ Sickle Cell Anemia
❑ Bleeding Disorders	❑ Eating Disorder	❑ HIV +/AIDS	❑ Nose/Throat Disease	❑ Thyroid Disease
❑ Bones/Joints	❑ Fainting	❑ Intellectual Disability	❑ Pregnancy (teen)	❑ Tuberculosis

Please explain: _____

_____

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

What is the greatest concern you have regarding your child's teeth? _____

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... ❑ Yes ❑ No

   If yes, please list: _____
2. Is the child allergic to anything? i.e. medications, latex or food? ..... ❑ Yes ❑ No

   If yes, please list: _____
3. Has the child ever had a serious illness? If yes, when _____ Please describe _____ ❑ Yes ❑ No
4. Does the child have a history of any other illnesses? If yes please list _____ ❑ Yes ❑ No
5. Is the child currently being treated for any illness? ..... ❑ Yes ❑ No
6. Has the child ever been hospitalized? ..... ❑ Yes ❑ No
7. Has the child ever had a complication to general anesthetic? ..... ❑ Yes ❑ No
8. Does the child have any speech difficulties? ..... ❑ Yes ❑ No
9. Has the child ever had a blood transfusion? ..... ❑ Yes ❑ No
10. Is the child physically, mentally, or emotionally impaired? ..... ❑ Yes ❑ No
11. Does the child experience excessive bleeding when cut? ..... ❑ Yes ❑ No
12. Has the child ever had any negative dental or medical experiences? ..... ❑ Yes ❑ No
13. Has the child ever suffered any injuries to the mouth, head or teeth? ..... ❑ Yes ❑ No
14. What type of water does your child drink? ❑ City Water ❑ Well Water ❑ Bottled Water ❑ Filtered Water
15. Is fluoride toothpaste used? ..... ❑ Yes ❑ No
16. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____
17. Has either parent had a lot of tooth decay? ..... ❑ Yes ❑ No
18. Has the child had a recent toothache? ..... ❑ Yes ❑ No
19. Does the child suck his/her thumb, fingers or pacifier? ..... ❑ Yes ❑ No
20. Does the child participate in sports? If yes, please list: _____ ❑ Yes ❑ No

As a minor child, it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete treatment, including diagnostic radiographs. Protective restraints are used only when children may harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. If my child ever has a change in his/her health, I will inform the doctor at the next appointment without fail. I will be responsible for the cost of this dental treatment.

Signature _____ **Relation to child** _____ **Date** _____

For office use only: ❑ Premedication ❑ Medical Alert ❑ Allergies Reviewed by: _____ Date _____