Wilderness Station Pediatric Dentistry | Dr. Martin D. Killeen, DDS

8020 S. 13th Street | Lincoln, NE 68512 | 402.420.8020

Today's Date_____

Child's Name_____

Preferred Name_____ Age_____ Date of Birth_____ Sex: ☐ Male ☐ Female

Attends what school_____ Grade_____

Names & ages of siblings_____

Legal Guardian #1 _____ SS#_____

Relationship to child_____ Email _____

Date of Birth_____ Home Phone_____ Cell Phone _____

Address_____ City_____ State_____ Zip_____

Employed by_____ Work Phone_____

Employer address_____

Legal Guardian #2 _____ SS#_____

Relationship to child_____ Email _____

Date of Birth_____ Home Phone_____ Cell Phone _____

Address_____ City_____ State_____ Zip_____

Employed by_____ Work Phone_____

Employer address_____

Parents are: Married Single Divorced – Child lives with _____

Emergency Contact_____ Phone number_____

*How did you find us?*_____

A written cost estimate will be provided before treatment services. If your insurance fails to pay our office, you will be responsible for the balance. We will be glad to process any insurance claim forms. However, your co-payment will be due at the time of service. Our office requires one of the following arrangements for payment of fee at time of service.

Please circle your preference: Cash Personal check Visa/Mastercard Care Credit

Primary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address:_____
Insurance Co. Phone#:_____
Group/Policy#_____
ID#_____ SS#_____
Insured Name:_____
Relationship to Patient:_____
Insured Date of Birth:_____
Insured's Employer:_____

Secondary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address:_____
Insurance Co. Phone#:_____
Group/Policy#_____
ID#_____ SS#_____
Insured Name:_____
Relationship to Patient:_____
Insured Date of Birth:_____
Insured's Employer:_____

I authorize the release of any information regarding this claim and authorize payment of insurance benefits directly to Wilderness Station Pediatric Dentistry. I acknowledge that Wilderness Station Pediatric Dentistry has presented and made available to me their "Notice of Privacy Practices" for protected health information (available on website or upon request). I authorize Wilderness Station Pediatric Dentistry to use and disclose my Protected Health Information for treatment, payment and healthcare operations.

Signature_____ **Date**_____

Child Health/Dental History

Does your child have a history of, or conditions related to, any of the following? (Circle all that apply or add below):

Abnormal Bleeding	Cancer	Growth Problems	Liver Disease	Seizures
Anemia	Cerebral Palsy	Hearing Impairment	Lung Disease	Sickle Cell Anemia
Asthma	Cleft Lip/Palate	Heart/Heart Defect	MRSA	Thyroid Disease
Attention Deficit	Developmental Delay	Hemophilia	Muscle Disorder	Tuberculosis
Autism Spectrum	Diabetes	Hepatitis	Nose/Throat Disease	Other: _____
Bladder/Kidney	Down Syndrome	HIV+/AIDS	Psychiatric Treatment	_____
Bleeding Disorders	Eye Disorder	Intellectual Disability	Recurrent Headaches	_____
Bones/Joints	Fainting	Latex Allergy	Rheumatic Fever	_____

Please Explain:_____

_____

Name of Physician:_____ Phone:_____

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

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?.....1. If yes, please list:_____	☐	☐
2. Is the child allergic to anything? i.e. medications, latex or food?.....2. If yes, please explain:_____	☐	☐
3. Has the child ever had a serious illness? If yes, when_____ Please describe_____3.	☐	☐
4. Does the child have a history of any other illnesses? If yes, please list _____4.	☐	☐
5. Is the child currently being treated for any illness?.....5.	☐	☐
6. Has the child ever been hospitalized? If yes, please explain_____6.	☐	☐
7. Has the child ever had a complication to general anesthetic?.....7.	☐	☐
8. Does your child have any medical condition that requires a pre-med?.....8.	☐	☐
9. Is this the child's first visit to the dentist? If not the first visit, when was the last dental visit?_____9.	☐	☐
10. Has the child had a recent toothache?.....10.	☐	☐
11. Has the child ever had any negative dental or medical experiences?.....11.	☐	☐
12. Has the child ever had any dental radiographs (x-rays) taken?.....12.	☐	☐
13. Has the child ever suffered any injuries to the mouth, head or teeth?.....13.	☐	☐
14. Does the child take fluoride supplements?.....14.	☐	☐
15. Is fluoride toothpaste used?.....15.	☐	☐
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?.....17.	☐	☐
18. Does the child suck his/her thumb, fingers or pacifier?.....18.	☐	☐
19. At what age did the child stop bottle feeding?_____ Breast Feeding? Age_____		
20. Does your child snore?.....20.	☐	☐
21. Does the child participate in sports? If yes, please list:_____21.	☐	☐
22. Does your child eat sugar coated cereal for breakfast?.....22.	☐	☐
23. Does your child drink juice or pop on a daily basis?.....23.	☐	☐
24. Does the child ever fall asleep while drinking milk or juice?.....24.	☐	☐

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. Some members of our team have acquired additional certifications that allow them to provide additional levels of care. All of our staff is licensed in their area of practice and expertise. 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. For specific procedures, further information will be provided.

Signature_____ **Relation to child**_____ **Date**_____