1116 South 105th St.
Omaha NE 68124
www.thomsendental.com
(402)393-1992

Thomsen Dental Group PC

Date

Patient Name: Last | First | MI | Preferred Name

Birth Date: | Male | Female | School and Grade

Hobbies and Special Interests

Address:

City | State | Zip Code

Patient's Phone: Home | Work | Mobile

Father's Name: | Father's Phone:

Address:

City | State | Zip Code

Employer and Occupation:

Mother's Name: | Mother's Phone:

Address:

City | State | Zip Code

Employer and Occupation:

Who will be responsible for payment of your child's dental services? Include social security number and date of birth.

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Does your child have any immediate dental problems? If yes, please describe.

Date of last dental visit and what was done for your child at that time?

Describe your child's general health

◯ Excellent ◯ Good ◯ Fair

Does your child have any fear of medical or dental offices?

◯ Yes ◯ No

Is your child taking any medications?

Is your child now under the care of a physician?

Physician's name and phone number

Has your child had any of the following? Please circle those that apply.

Penicillin Allergy	Respiratory Problems	Dizziness
Heart murmur	Allergies	Head Injury
Heart disease	Hay Fever	Hepatitis
Abnormal Bleeding	Asthma	Jaundice
Epilepsy or Seizures	Anemia	Radiation Treatment

Please add any additional information which may help us in caring for your child.

Whom may we thank for referring you to our practice?

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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 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 any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

Signature of parent or guardian [responsible party]:

Signature: _____ Date: _____

Printed Name: _____