Dear Patient:

Welcome to the office of Dr. Susan Christensen! Thank you for choosing Eastview Family Dental. This packet provides important information to help you become familiar with our practice. We welcome the opportunity to introduce ourselves and look forward to providing you with gentle, exceptional care.

A little bit about us: Dr. Sue Christensen grew up in Lincoln, attended Southeast High School and graduated from the University of Nebraska College of Dentistry in 1981. As a third-generation dentist, she continues to uphold the same values that were important to her grandfather, Dr. Merrit Pederson and her father Dr. Harold Maude. Her philosophy of dental care is one of prevention and preservation in the most comfortable and conservative way.

More about us: We are devoted to maintaining, restoring, and enhancing your healthy smile and oral health. We offer a full scope of general and cosmetic dentistry and utilize conservative procedures with state-of-the-art technology that will result in a healthy, beautiful and long-lasting smile for you!

To provide you with a great first visit that is focused on your oral health, we would like to ask that you please complete all the enclosed paperwork and bring the forms to your scheduled appointment.
Please bring the following to your appointment:

- Completed Paperwork
- Completed Health History Forms (listing current medications and doses)
- HIPAA Agreement
- Financial Agreement
- Dental Insurance Card
- Identification Card such as driver's license
- Any Doctor Release if needed, due to recent surgery or replacement surgery
- Any Dental X-rays you have had taken within the last 5 years, they can be requested from your previous dentist and emailed to us at finance@eastviewfamilydental.com

Our location: On the North side of South Street between S. 56th and S. 57th Street

Cancellation Policy: We ask for help from our patients when it comes to keeping their commitment to their scheduled appointments. Please call as soon as possible if it becomes necessary to re-schedule your appointment with us.

Financial: Payment is expected at the time of service. For your convenience, our office will file your dental insurance claim If you have dental insurance, we will do our best to give you your estimated fee due for services and anything remaining would be billed to you after your insurance claim is paid. We accept Cash, Checks, Credit Cards, HSA Cards, and CareCredit. Please let us know if you have any questions concerning financial arrangements, we are happy to assist you!

Thank you for choosing Eastview Family Dental – Where Technology and Comfort Meet! When you visit our office, you will experience genuine compassion combined with state of the art technology to provide you with the exemplary level of care you deserve.

WELCOME to Eastview Family Dental, Dr. Susan Christensen's Office

Date: _____/_____/_____

Youth Patient Information (18 and under):

_____ DOB: ____/_____/_____ Phone: _____-_____-_____
First M. Last

Address:_____City:_____State:_____Zip:_____

Email:_____SOC#: _____-_____-_____

Please indicate how you wish to be contacted for appointment confirmation (circle all that apply): Text Phone Call email

Who may we thank for referring you: _____

Emergency Contact: _____Relationship: _____Phone: _____-_____-_____

Name of School/College: _____City: _____State: _____
If you are attending College, are you: ☐ Full-Time or ☐ Part-Time

Parent/Guardian and Responsible Party Information:

Mother's/Guardian's name_____ DOB: ____/_____/_____ Phone: _____-_____-_____
☐ Custodial Parent/Guardian ☐ Non-Custodial Parent/Guardian or ☐ N/A

Address:_____City:_____State:_____Zip:_____

Email:_____SOC#: _____-_____-_____

Father's/Guardian's Name: _____ DOB: ____/_____/_____ Phone: _____-_____-_____
☐ Custodial Parent/Guardian ☐ Non-Custodial Parent/Guardian or ☐ N/A

Address:_____City:_____State:_____Zip:_____

Email:_____SOC#: _____-_____-_____

May Eastview Family Dental release information to non-custodial parent? ☐ Yes ☐ No ☐ N/A

Name of person responsible for your account: _____ Phone: _____-_____-_____
Relationship to responsible party: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other _____

Address:_____City:_____State:_____Zip:_____

Email:_____DOB: ____/_____/_____SOC#: _____-_____-_____

Employer: _____ Phone: _____-_____-_____

Is this person currently a patient of our office? ☐ yes ☐ no

Continue on the back side of this form…

For your convenience, we will submit your dental claim, in addition, we offer the following methods of payment:

Cash, Check, Credit Card, HSA Card, CareCredit. (See Financial Policy in this packet)
Please let us know if you have any questions regarding our payment options.

Insurance Information:

Name of Insured: _____ *Insured Phone:* _____-_____-_____

Is this person currently a patient of our office? ☐ yes ☐ no

*Insured's Address:*_____*City:*_____*State:*_____*Zip:*_____

*Email:*_____*DOB:* ____/_____/_____*SOC#:* _____-_____-_____

Employer _____ *Phone:* _____-_____-_____

Employer Address:-
_____*City:*_____*State:*_____*Zip:*_____

Do you have an additional dental Insurance policy? ☐ *yes* ☐ *no*

Secondary Insurance Information:

Name of Insured: _____ *Insured Phone:* _____-_____-_____

Is this person currently a patient of our office? ☐ yes ☐ no

*Insured's Address:*_____*City:*_____*State:*_____*Zip:*_____

*Email:*_____*DOB:* ____/_____/_____*SOC#:* _____-_____-_____

Employer _____ *Phone:* _____-_____-_____

Employer Address:-
_____*City:*_____*State:*_____*Zip:*_____

_____ _____/_____/_____
Signature of Responsible Party *Date*
(all information is correct and complete to your knowledge)

Office Use:
Insurance Yearly Maximum Benefit:
Annual deductible:
Preventitive:_____Basic:_____Major:_____Ortho:_____

Replacement policy:_____