UNMC COLLEGE OF DENTISTRY
APPLICATION FOR DENTAL TREATMENT

CHILD'S NAME		ADDRESS	
PHONE	CITY	STATE	ZIP
SEX	BIRTH DATE	SOCIAL SECURITY NUMBER	PRIMARY LANGUAGE
Parent/Guardian Name		EMERGENCY CONTACT	

PARENT INITIALS *Please initial in the boxes that you understand, agree to, consent to or have received as appropriate for the information to the right of the box.*

☐ I hereby apply for acceptance of my child as a patient at the College of Dentistry. I am aware that dental treatment will be rendered by students under the supervision of faculty who are licensed practitioners.

☐ I understand that my child's treatment by students will require considerably more time than if it were to be performed by an experienced dental practitioner. I understand that there is a possibility that only a portion of my child's total dental needs will be provided due to the unique requirements of teaching institutions. I also understand that there is no guarantee or warranty that the results of the treatment to be rendered will be to my complete satisfaction, although it is believed that such results will be satisfactory.

☐ I will make known any diseases, allergies, or unusual reactions to drugs or medicines that have occurred to my child in the past.

☐ I understand that all original dental records, X-ray films, and diagnostic aids are the property of the University of Nebraska and cannot be taken, or sent, from the College of Dentistry. Copies will be provided upon request.

☐ I have received a copy of the University of Nebraska Medical Center Privacy Notice.

☐ I consent to dental care and treatment for my child including but not limited to diagnostic procedures, dental examination and treatment by students, faculty and staff of the UNMC College of Dentistry. I acknowledge that no guarantees have been made to me as to the results of the diagnosis, treatments, tests or examinations.

SIGNATURES

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON (AGE 19 OR OLDER)	DATE SIGNED (M/D/Y)
SIGNATURE OF WITNESS	

Does your child have Medicaid? Yes No If Yes, What is your child's Medicaid number _____

Does your child have Kids Connection? Yes No If Yes, What is your child's Kids Connection number? _____

UNMC COLLEGE OF DENTISTRY
MEDICAL HISTORY

Child's Name _____ Child's Age _____

Please answer each question about the medical history of your child. Please give details if you answer yes for any question.

Has your child had:	*Circle Yes or No*		*Please explain if yes*
1. Heart or blood pressure problems (including heart murmur)	Yes	No	
2. Convulsions, seizures or numbness	Yes	No	
3. Problems with the lungs (including asthma and tuberculosis)	Yes	No	
4. Kidney or bladder problems	Yes	No	
5. Hepatitis or other liver problems	Yes	No	
6. Stomach or intestinal problems	Yes	No	
7. Diabetes	Yes	No	
8. Thyroid or other hormone problems	Yes	No	
9. Arthritis or rheumatism	Yes	No	
10. Blood disorders, anemia or transfusions	Yes	No	
11. Bleeding problems	Yes	No	
12. HIV or AIDS	Yes	No	
13. Eye, ear, nose or throat problems	Yes	No	
14. Allergies (including antibiotics, dental anesthetics, latex, pain pills)	Yes	No	
15. Cancer or tumors	Yes	No	
16. Radiation therapy (for cancer or tumors)	Yes	No	
17. Other medical problems	Yes	No	
18. Is your child currently under the care of a Physician?	Yes	No	
19. Is your child currently taking any medications? If so, please list.	Yes	No	

Parent/Guardian Signature _____ Date _____

University of Nebraska Medical Center

COLLEGE OF DENTISTRY
Office of Academic Affairs

DENTAL DAY

PARENTAL AUTHORIZATION TO ADMINISTER PAIN CONTROL MEDICINE

Sometimes patients experience irritation and soreness in their mouth after seeing the dentist. This form authorizes the College of Dentistry to administer a pain control medication after the dental appointment in order to make your child more comfortable during the ride home. If you agree to authorize the administration please circle the approved medication and sign below. The supervising dentist will prescribe and administer the most appropriate medication for your child at the College.

I approve of using:

IBUPROFEN

Signature of Parent
or Legal Guardian:_____ _____
Date

40th & Holdrege, P. O. Box 830740, Lincoln, NE 68583-0740
(402) 472-1344 / FAX (402) 472-6681 / E-mail: dgbrown@unmc.edu

MEDIA AUTHORIZATION FORM

Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Description of Information to be released:

_____

_____

Reporter/Affiliation: _____ Possible air/publication date: _____

Consent to: ☐ interview ☐ photography ☐ videotape ☐ other

In the interest of education and advancement of the health sciences, I, the undersigned, voluntarily authorize The Nebraska Medical Center/University of Nebraska Medical Center (Hospital/UNMC) and its employees and agents to take photographs, produce newspaper or magazine articles, television programs, videotape recordings, internet materials and other visual and/or audio recordings in which I may be included in whole or in part for showing to the general public for publicity and promotion. I have had the opportunity to ask questions about the potential uses of the interview/photograph/videotape or other audiovisual.

☐ I consent to having my name identified with the materials. ☐ I prefer not to be identified by name.

I grant this authorization and give my consent as a voluntary contribution to the advancement of medical and other health sciences and education. Therefore, I waive the following: (1) any proprietary rights in the materials, and (2) any right I may have to inspect or approve the finished materials prior to publication.

I understand that the entities that receive the information may not be covered by federal privacy regulations, and that the information described above may be used again by the recipient.

I understand that Hospital/UNMC ☐ will/☐ will not receive compensation for its use/disclosure of the information.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment (if applicable).

I understand that I may withdraw this authorization in writing at any time by notifying _____
(staff name/phone)

I understand that Hospital/UNMC may not be able to honor my request to withdraw this authorization if the information has already been released.

I release The Nebraska Medical Center/University of Nebraska Medical Center and its employees and agents from any claims arising from the use of such materials.

_____ _____
Signature of Individual Signature of parent, guardian, or authorized Representative

_____ _____
Date Relationship of above person to individual

_____
Witness

University of Nebraska Medical Center

The Nebraska Medical Center

CON-0043 (Rev. 7/03)

MEDIA AUTHORIZATION FORM

White Copy—Public Relations Yellow Copy—Patient