



Central Dental Group^{PC}

Ann M. Heckman, D.D.S
Nathan F. Thompson, D.D.S

Date: _____

Patient Legal Name: _____ Nickname: _____

Sex: _____ Date of Birth: _____ SS#: _____

Address: _____ City, State, Zip: _____

Preferred Phone: _____ Alternate Phone: _____
Home Cell Work Home Cell Work

Employer: _____ Work Phone: _____

Spouse Name: _____ Date of Birth: _____ SS#: _____

Spouse Employer: _____ Work Phone: _____

Emergency Contact Person: _____ Phone: _____

Nearest relative not living with you: _____

Address: _____ Phone: _____

Do you have dental insurance? Yes _____ No _____ Medicaid? Yes _____ No _____
If yes, please sign here for release of information and assignment of benefits, and give your card to the receptionist to copy.

Signature: _____

Who is financially responsible for this account? _____

I will be paying today by cash _____ check _____ credit/debit card _____.

Whom may we thank for referring you to our office? _____

Address: _____ Phone: _____

Please complete reverse side

Physicians Name and Address: _____

May we request your health records if necessary? Yes____ No____

Has your physician ever recommended antibiotic pre-medication prior to your dental procedures?
Yes____ No____ If yes, Why?_____

Please list all current medications. (We will be happy to photocopy if you have a list)

Are you allergic to Penicillin?____ Codeine?____ Local Anesthetics?____ Latex?____
Other Drugs:____ Please List:_____

Have you ever had or do you now have?

	Yes	No		Yes	No
Abnormal Blood Pressure	___	___	Allergies	___	___
Abnormal Bleeding	___	___	Arthritis	___	___
AIDS/HIV	___	___	Asthma	___	___
Artificial Heart Valves	___	___	Drug Dependency	___	___
Artificial Joints	___	___	Fainting	___	___
Date Replaced_____			Glaucoma	___	___
Cancer/Chemotherapy	___	___	Herpes/Canker Sores	___	___
Diabetes	___	___	Major Surgery	___	___
Epilepsy	___	___	Psychiatric Treatment	___	___
Heart Disease	___	___	Thyroid Disease	___	___
Liver Disease	___	___	Tuberculosis	___	___
Organ Transplant	___	___	Ulcers	___	___
Pacemaker	___	___	Venereal Disease/STD	___	___
Blood Thinners	___	___	Smoke/Tobacco	___	___
Stroke	___	___	Bone Density Medication	___	___
			(Osteoporosis)		

Have you had a disease, condition, or problem not previously listed?

If yes, what? _____

Females: Are you taking hormones or birth control? Yes____ No____
Are you pregnant? Yes____ No____ Are you nursing? Yes____ No____

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? Yes____ No____

Date of last dental visit _____

How do you feel your dental health is Good____ Fair____ Poor____

Have you had any serious problems associated with any previous dental treatments? Yes____ No____

Do your gums bleed? Yes____ No____

Do you like your smile? Yes____ No____

I hereby certify that the above information is correct to the best of my knowledge.

Signature _____



Central Dental Group^{PC}
515 WEST 9TH STREET
PO BOX 787
HASTINGS NE 68901

**FINANCIAL POLICY
EFFECTIVE JANUARY 1, 2018**

Thank you for choosing us as your health care provider. We are committed to your treatment and being successful. To avoid any misunderstanding the following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

All patients must complete a patient information form before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, OR CREDIT / DEBIT.

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will accept assignment of insurance benefits after credit has been established. However, full payment of your account is due 30 days after treatment if the insurance company has not paid. We will be happy to file your insurance for you; however, we do need a copy of your current insurance card or a completed insurance form. We ask that you look upon your insurance company as a device that reimburses you for a portion of your dental expenses, not as a device that covers all expenses.

SERVICE CHARGE

A 1.5% service charge will be assessed on accounts 90 days past due, regardless of pending insurance claims.

ADULT PATIENTS

Adult patients are responsible for full payment at the time of service.

MINOR PATIENTS

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, financial arrangements must be made prior to treatment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Ours is a practice built on education, communication, honesty, and sincerity.

I have read the financial policy. I understand and agree to the Financial Policy.

Signature

Date