



# Central Dental Group<sup>PC</sup>

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Date: \_\_\_\_\_

Patient Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Sex: \_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Preferred Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
Home Cell Home Cell

Do you text: Yes \_\_\_\_ No \_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have dental insurance? 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 \_\_\_\_.

How did you hear about our office? \_\_\_\_\_

Please complete reverse side

Physicians Name and Address:

\_\_\_\_\_  
May we request your health records if necessary? Yes\_\_\_ No\_\_\_

Has your physician recommended antibiotic 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<sup>PC</sup>  
515 WEST 9<sup>TH</sup> 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.

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Signature

Date