Central Dental Group P.C.

Ann M. Heckman, D.D.S
Nathan F. Thompson, D.D.S
Mikaela N. Shaw, D.D.S.

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 _____.

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 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 _____


**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