Central Dental Group P.C.

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

Date:_____

Patient Name:_____ Sex:___ Date of Birth:_____

Address:_____ City, State, Zip:_____

SS#:_____ Preferred Phone:_____ Alt Phone:_____
☐Home ☐Cell ☐Work ☐Home ☐Cell ☐Work

Father's Name:_____ Date of Birth:_____ SS#:_____

Address:_____ City, St., Zip:_____

Father's Employer: _____ Work Phone: _____

Mother's Name: _____ Date of Birth: _____ SS#: _____

Address:_____ City, St., Zip:_____

Mother's 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.

Parent/Guardian 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.

Parent/Guardian Signature _____

Central Dental Group P.C.

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