We are delighted to welcome you to our practice and thank you for choosing us as your dental team. We strive to provide our patients with the highest quality dentistry tailored to each patient's desires in a warm and caring environment.

We are committed to excellence and providing you the best dental care at reasonable fees. Our goal is to help you have a beautiful, healthy smile that makes you feel and look great.

We believe that every patient deserves information and the choices they have in dentistry today to achieve their lifetime strategy for dental health. The way we begin that care is to provide a comprehensive evaluation.

During your first visit, a thorough oral examination will be completed. This will include radiographs and other diagnostic aids necessary to determine indicated dental treatment. Radiographs are an extremely important part of this comprehensive evaluation, without them, a proper diagnosis cannot be made. If you have been to another dental provider within the last year and radiographs were taken, we ask you to bring these current x-rays with you to your initial appointment. Please do not mail them. If you do not bring them, or they are not of adequate quality, new radiographs will be taken at the initial appointment in order to provide you with a proper diagnosis.

After your comprehensive examination, you will receive a thorough explanation of our diagnostic findings and then we may reserve time for a personalized consultation to discuss your treatment options as necessary. We do not reserve time to "clean" your teeth until we have completed our initial examination and determined what treatment is appropriate for you. We will work with you to reserve any necessary appointments and make appropriate financial arrangements.

This packet includes our patient profile, dental and medical history forms. Please complete them prior to your appointment, and mail them or bring them to the office with you. Your answers will assist us in satisfying your specific dental needs.

If you have any questions, please call us at one of the phone numbers listed below. We look forward to meeting you at your appointment. Thanks again for choosing our dental practice.

Sincerely,

Omni Dental Team

Our Team's Mission at Omni Dental is to provide quality, comprehensive dental care in a professional environment, which meets the diverse needs of our patients. We constantly strive to provide ongoing education to our patients in order to optimize their overall health and well being.

Patient Information (CONFIDENTIAL)

SS#/SIN_____________________________
Date of Birth__________________________

Name____ Preferred Name____________________________
(Last) (First) (MI)
Address____ City____________________ State________ Zip____________

Home phone________________________ Cell phone________________________ E-mail______________________________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Male ☐ Female

If Student, Name of School/College__________________________________ City____________________ State________ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer____ Work phone________________________

Business Address____ City____________________ State________ Zip__________

Spouse or Parent/Guardian's Name__________________________ Employer_______________________ Work Phone______________

Whom May We Thank for Referring You? ________________________________How did you hear about us? ________________________

Person to Contact in Case of Emergency____ Phone_________________

Responsible Party (if other than above)

Name of Person Responsible for this Account____ Relationship To Patient_______________________

Address____ City____________________ State______ Zip____________

Home phone________________________ Cell phone________________________ E-mail______________________________________

Driver's License #_______________________________ Date of Birth______________________ SS#/SIN___________________________

Employer____ Work Phone______________________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer.
PAYMENT IN FULL AT EACH APPOINTMENT
☐ Cash ☐ Personal Check ☐ Credit Card ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured____ Relationship To Patient______________________

Date of Birth____ SS#/SIN____

Name of Employer____ Union or Local #________________ Work Phone______________

Address of Employer____ City____________________ State_____ Zip__________

Dental Insurance Company____ Group #_____________ Policy/ID #____________

How Much is your Deductible?______________ How Much Have You Used?_______________ Max. Annual Benefit______________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured____ Relationship To Patient______________________

Date of Birth____ SS#/SIN____

Name of Employer____ Union or Local #________________ Work Phone_____________

Address of Employer____ City____________________ State_____ Zip__________

Dental Insurance Company____ Group #_____________ Policy/ID #____________

How Much is your Deductible?_______________ How Much Have You Used?______________ Max. Annual Benefit______________________

Patient Medical History

Physician______________________________ Office Phone_________________________ Date of Last Medical Exam____________

Question	YES	NO
1. Are you under medical treatment now?………………………	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?……….	☐	☐
If yes, please explain________________________________		
3. Are you taking any medication(s) including non-prescription medicine?……………………………………...	☐	☐
If yes, what medications are you taking?_______________		
4. Have you ever taken Fen-Phen/Redux?……………………..	☐	☐
5. Do you use tobacco?…………………………………………...	☐	☐
6. Do you use or have you used controlled substances?……...	☐	☐

Question	YES	NO
8. Are you allergic to or have you had any reactions to the following?………………………………………………………..		
Local Anesthetics (e.g. Novocain)……………………………	☐	☐
Penicillin or other Antibiotics…………………………………	☐	☐
Sulfa Drugs……………………………………………………..	☐	☐
Barbiturates…………………………………………………….	☐	☐
Sedatives………………………………………………………..	☐	☐
Iodine……………………………………………………………	☐	☐
Aspirin…………………………………………………………..	☐	☐
Any Metals (e.g. nickel, mercury, etc.)………………………	☐	☐
Latex Rubber……………………………………………………	☐	☐
Other (please list)_________________________________		
9. Do you have a persistent cough or throat clearing not associated with a known illness (last more than 3 weeks)?.	☐	☐
10. Women Only:		
a) Are you pregnant or think you may be pregnant?……….	☐	☐
b) Are you nursing?……………………………………………	☐	☐
c) Are you taking oral contraceptives?………………………	☐	☐

7. Do you have or have you had any of the following?

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
Heart Disease…………………………	☐	☐	Joint Replacement or Implant………	☐	☐	Asthma…………………………………	☐	☐
Heart Attack……………………………	☐	☐	Cancer…………………………………	☐	☐	Fainting……………………………….	☐	☐
High Blood Pressure………………..	☐	☐	Radiation Therapy…………………..	☐	☐	Low Blood Pressure…………………	☐	☐
Rheumatic Fever…………………….	☐	☐	Chemotherapy………………………	☐	☐	Epilepsy / Seizures……………….	☐	☐
Mitral Valve Prolapse……………….	☐	☐	Leukemia……………………………	☐	☐	Thyroid Problem…………………….	☐	☐
Heart Murmur………………………...	☐	☐	Anemia………………………………	☐	☐	Emphysema………………………….	☐	☐
Cardiac Pacemaker………………….	☐	☐	AIDS or HIV Infection……………...	☐	☐	Arthritis……………………………….	☐	☐
Heart Bypass Surgery……………….	☐	☐	Diabetes…………………………….	☐	☐	Sexually Transmitted Disease……...	☐	☐
Angina / Chest Pain…………………	☐	☐	Kidney Disease……………………..	☐	☐	Stomach Trouble / Ulcers………….	☐	☐
Stroke…………………………………	☐	☐	Hepatitis……………………………..	☐	☐	Hay Fever / Allergies……………….	☐	☐
Swollen Ankles………………………..	☐	☐	Liver Disease………………………..	☐	☐	Recent Weight Loss…………………	☐	☐
Easily Winded………………………..	☐	☐	Glaucoma……………………………	☐	☐	Other_______________________	☐	☐
Respiratory Problems……………….	☐	☐	Tuberculosis………………………..	☐	☐			

Patient Dental History

Name of Previous Dentist and Location____ Date of Last Exam___________________

Question	YES	NO
1. Do your gums bleed while brushing or flossing?…………..	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?…….	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?….	☐	☐
4. Do you feel pain to any of your teeth?………………………	☐	☐
5. Do you have any sores or lumps in or near your mouth?…	☐	☐
6. Have you had any head, neck or jaw injuries?……………	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking?………………………………………………………	☐	☐
Pain (joint, ear, side of face)?………………………………	☐	☐
Difficulty in opening or closing?……………………………	☐	☐
Difficulty in chewing?………………………………………..	☐	☐

Question	YES	NO
8. Do you have frequent headaches?………………………	☐	☐
9. Do you clench or grind your teeth?………………………	☐	☐
10. Do you bite your lips or cheeks frequently?……………...	☐	☐
11. Have you ever had any difficult extractions in the past? Oral surgery?…………………………………………	☐	☐
12. Have you ever had any prolonged bleeding following extractions?………………………………………………..	☐	☐
13. Have you had any orthodontic treatment?………………..	☐	☐
14. Do you wear dentures or partials?………………………	☐	☐
If yes, date of placement_____________________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?……………..	☐	☐
16. Do you like your smile?……………………………………..	☐	☐
17. Would you like to change anything?……………………….	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. *I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

X

Signature of Patient (or parent/guardian if minor) Date

Patient Consent Form

Omni Dental
300 W Broadway, Ste 30
Council Bluffs, IA 51503

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _________________________

Signature: _________________________

Relationship to Patient: _________________________

Date: ______________

Omni Dental Financial Guidelines

Our aim is to provide each patient with quality, comprehensive dental care in a professional environment which meets the diverse needs of our patients. Our dental office is a business that must be managed efficiently if we are to continue serving our community with quality aesthetic, restorative, and preventive dentistry. Our fees are fair and reflect the care and expertise with which we treat each patient.

To keep our fees from rising considerably and to minimize the expenses of billing and bookkeeping, we offer patients payment options. **We ask that all accounts be paid in order to reserve an appointment unless other arrangements have been made with the financial office.**

INSURANCE

Insurance claims will be processed through our business office on a company-by-company basis. Patients with insurance are responsible for the entire fee prior to treatment, unless our practice accepts assignment of benefits from your particular company. In this case the patient is responsible for his or her estimated portion of the fee prior to treatment.

PAYMENT METHODS

Cash: This includes money orders, personal checks and cashier checks

Bank Cards: Cards accepted include MasterCard, Visa, American Express, and Discover.

Healthcare Financing: If you need extended payments, we have excellent options. Care Credit and Citi Health are lines of healthcare credit, which allow you to pay as little as 3% of your balance per month. The initial charge amount may have an interest free period. Please ask a staff member for details. Once approved, the monthly payments are made to our Healthcare Financing Partner.

We have convenient office hours to serve our patients and we reserve appointment time exclusively for each patient. We will work with you to schedule times that maximize your care in the shortest number of appointments. When we reserve an appointment for a patient, the focus of the doctor and the hygienist is only on that patient’s care and the time allowed is very important. Each appointment in a patient’s treatment schedule moves them closer to completing their needed dentistry. We ask for a 48 hour notice if you are unable to keep a scheduled appointment time.

Our main purpose for having guidelines is to keep our patients informed of their choices and obligations.
We want to serve your dental needs and handle the business aspect through a clear understanding by all parties involved. If you have any questions, please contact us in person or by telephone. Each patient will receive a treatment plan with the fees and choices for payment options.

I understand and have read all of the information on this form. I understand and agree that I am responsible for all treatment fees on my account. I understand that if my insurance does not pay for any treatment or pays less than anticipated, I am responsible for the entire balance.

____

Print Name Signature Date

Smile Evaluation

Name____ Date________________

1. Do you like the way your teeth look? Yes ☐ No ☐

   Explain:____

2. Are you happy with the color of your teeth? Yes ☐ No ☐

   Explain:____

3. Would you like for your teeth to be whiter? Yes ☐ No ☐

   Explain:____

4. Would you like your teeth to be straighter? Yes ☐ No ☐

   Explain:____

5. Do you have spaces between your teeth that you would like closed? Yes ☐ No ☐

   If so, where?____

6. Would you like your teeth to be longer? Yes ☐ No ☐

   If so, Upper____ Lower______ Both_______?

7. Do you like the shape of your teeth? Yes ☐ No ☐

   Explain:____

8. Do you have missing teeth that you would like to replace? Yes ☐ No ☐

   Explain:____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings?
   Yes ☐ No ☐

   Explain:____

10. If you could change anything about your smile, what would you change?

    ____

    ____