Omni Dental

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 the 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 appointment, a thorough oral evaluation 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 evaluation, 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 will work with you to reserve any necessary appointments and make appropriate financial arrangements.

Enclosed is our patient profile, dental and medical history forms. Please complete them prior to your appointment, and email, fax, or bring them to the office with you. Your answers will assist us in satisfying your specific dental wants and 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.

Thank you again for choosing our dental practice.

Sincerely,

Your Omni Dental Team

www.OmniDentalCentre.com

1026 Woodbury Ave
Council Bluffs, IA 51503
712-328-8573

3004 N 13th St
Carter Lake, IA 51510
712-347-6151

Our Team's Mission at Omni Dental is to effectively communicate with our patients in order to understand their wishes and desires and to provide ongoing education to optimize their overall health and well being. We will then offer extraordinary, comprehensive dental care in a professional environment which meets the diverse, individualized needs of our patients.

Patient Information

SS#/SIN_____
Date of Birth_____

Name_____ Preferred Name_____
(Last) (First) (MI)
Address_____ City_____ State_____ Zip_____

Home phone_____ Cell phone_____ E-mail_____

How did you hear about our office? _____

Check Appropriate Boxes: ☐ 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_____Dept_____ Work phone_____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone_____

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

Insurance Information

Name of Insured_____ Relationship To Patient_____

Date of Birth_____ SS#/SIN_____

Name of Employer_____Dept_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Dental Insurance Company_____ Group #_____ Policy/ID #_____

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 #_____

Please continue with update on reverse side of form.

Medical History

Name_____ Preferred Name:_____
(Last) (First) (MI)

Physician_____ Office Phone_____ Date of Last Medical Exam_____

	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. Do you take any medications for prevention of Osteoporosis? (Fosamax, Boniva, etc.)……	☐	☐
4. Have you had any joint replacements?..... If yes, which joint and when?_____	☐	☐
5. Do you have a persistent cough or throat clearing not associated with a known illness (last more than 3 weeks)?.	☐	☐
6. Have you ever taken Fen-Phen/Redux?……..	☐	☐
7. Do you use tobacco?……..	☐	☐
8. Do you use or have you used controlled substances?……..	☐	☐

	YES	NO
9. 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 including any foods (please list)_____		
10. Women Only:		
a) Are you pregnant or think you may be pregnant?……	☐	☐
b) Are you nursing?……	☐	☐
c) Are you taking oral contraceptives?……	☐	☐

Please list all medications you are currently taking including non-prescription: _____

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

	YES	NO		YES	NO		YES	NO
Heart Disease……	☐	☐	Tuberculosis……	☐	☐	Asthma……	☐	☐
Heart Attack……	☐	☐	Cancer……	☐	☐	Fainting……	☐	☐
High Blood Pressure……	☐	☐	Radiation Therapy……	☐	☐	Low Blood Pressure……	☐	☐
Rheumatic Fever……	☐	☐	Chemotherapy……	☐	☐	Epilepsy / Convulsions……	☐	☐
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……	☐	☐	High cholesterol……	☐	☐
Depression/anxiety……	☐	☐	Glaucoma……	☐	☐	Sleep Apnea……	☐	☐
Respiratory Problems……	☐	☐	Recent weight loss……	☐	☐	Other_____		

Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

Please state any dental concerns you have: _____

_____

	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?……	☐	☐

	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?……..	☐	☐
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

Omni's Smile and Sleep Evaluation...

*Name*_____ *Date*_____

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

   *Explain:*_____

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

   *Explain:*_____

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

   *Explain:*_____

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

   *If so, where?*_____

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

   *Explain:*_____

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

   *Explain:*_____

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

   _____

8. *Do you snore?* *Yes* ☐ *No* ☐

9. *Have you ever been diagnosed with sleep apnea?* *Yes* ☐ *No* ☐

10. *Do you wear any type of C-PAP machine, or other apnea appliance?* *Yes* ☐ *No* ☐

11. *How many hours of sleep do you get a night?* _____.

    Do you wake feeling rested? *Yes* ☐ *No* ☐

David L. Jones, D.D.S.
Robert W. Hurley, D.D.S.

Kara Mullins, D.D.S.
Nicholas Couse, D.D.S.
Aaron McCormick, D.D.S.

Omni Dental Financial Guidelines

Thank you for choosing Omni Dental Centre for your dental care. 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 preventative dentistry. Our fees are fair and reflect the care and expertise with which we treat each patient. The following details our office's financial policy:

- At each NEW patient visit, a copy of the patient's Driver's License or personal identification card will be requested as well as the social security number of the patient AND parents/guardians if the patient is a minor.
- If you have no dental insurance coverage, payment in full is due at the time of service unless other arrangements have been made with the business team and approved by the Patient Accounts Manager.
- If you need to extend payments, we have the option of Care Credit. Care Credit is a line of healthcare credit which allows you to pay as little as 3% of your balance per month. The initial charge may have an interest free period. Please ask a Business Team Member for details. Once approved, the monthly payments are made to our Healthcare Financing Partner, Care Credit.
- If you have dental insurance coverage, you must provide our office with your current insurance card or information annually or when there is a change in your coverage.
- Our office does NOT accept Medicaid Insurance, Dental Wellness Plan Insurance (DWP), or Hawk-i Insurance plans. If ANY of these are your dental insurance carrier, payment is required up front and in full on the date of service.
- Our office will file all dental insurance claims to accepted dental insurance plans. However, our office may not be an in-network provider for your insurance plan. It is ultimately the responsibility of the patient to determine Omni Dental Centre's status with your dental plan.
- We must emphasize that as a dental practice, our relationship is between you & our dentists, not the insurance company. While the filing of insurance claims is a courtesy we extend to our patients, it is often necessary for you to inquire and explore your dental benefits with your insurance carrier. At the time of service, we will provide you an estimate of your patient responsibility. However, it is an estimate and ultimately the patient is responsible for any portion of the charges deemed non-covered or noted as patient responsibility by the insurance company.

- If your current condition is a work related injury, you must provide the name of your workers compensation carrier, claim number, mailing address, and the name and phone number of your contact person/human resources person from your place of employment. We will gather your regular insurance information in the event your workers compensation claim is denied.
- Once insurance has processed the claim, you will receive a statement showing any remaining patient responsibility portion for your services. Payment in full is due 12 days from the statement date unless other arrangements have been made with the Patient Accounts Manager.
- Finance charges of 1.5% will be assessed accounts that are 30 days past due. This applies to accounts with unpaid balances after insurance has paid.
- Payments of cash, checks or credit cards are accepted in person at all locations.
- Checks or credit card payments may be mailed to our Business Office at 1026 Woodbury AVE, Council Bluffs, IA, 51503.
- For your convenience, payments via credit card (Visa/MasterCard/Discover/American Express) will be accepted over the phone by calling our business office at 712-847-8151.
- If you are unable to pay your balance in full at the time you receive your statement, please call and speak with one of the Patient Accounts Team to set up a payment arrangement.
- Omni Dental Centre partners with TekCollect to send statements on accounts with an unpaid balance after insurance claims have been paid. If accounts continue to age, they will be considered for collection activity and will have limited privileges for future appointments, prescription refills, etc. These limitations will be discussed with management and your dentist. Continued failure to make payments may result in a discharge from our practice.
- In the event of a divorce or separation, the custodial parent will be the party responsible for the account of a minor child unless a copy of a divorce decree or separation agreement is provided that details another party's responsibility. Although it is the intent of Omni Dental Centre to cooperate with such legal declarations, it is ultimately the responsibility of both parents to make certain the account is settled in full and to provide adequate information for filing insurance claims.
- There is a $50 fee for all returned checks.
- Our goal is to help you understand your financial responsibility. We want to serve your dental needs and handle the business aspect with a clear understanding by all parties involved. If you have any questions prior to your visit or after you have received the explanation of benefits from your insurance company or your statement, please do not hesitate to call our Patient Accounts Office at 712-847-8151 during the hours of 8:00 AM – 5:00 PM, Monday through Thursday and 8:00 AM – 3:00 PM on Friday.

List all patients this agreement applies to:_____

_____

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

_____ _____

Signature of patient or responsible party Date

_____

Printed Name

Patient HIPAA Consent Form

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 *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: _____

Staying within the “reasonable” guidelines of HIPAA, I give permission for Omni Dental to discuss my dental care and related issues with the following persons, in addition to myself. If none, please state so:

Name: Relationship:

_____

_____

_____

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of Omni Dental and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedures(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
   A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of the teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
   D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures).
   E. Removal (extraction) of one or more teeth.
   F. Treatment of diseased or injured oral tissues (hard and/or soft).
   G. Use of sedative drugs to control apprehension.
   H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me and that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

4. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

5. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

6. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

7. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

8. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date:_____

Patient Name:_____

Name of Parent or Guardian:_____

Signature of Patient or Parent or Guardian:_____

Facts Regarding Dental Insurance

Dental insurance is rapidly playing a larger role in helping people obtain dental treatment. Since we strongly feel that our patients deserve the best possible dental care we can provide, and in an effort to maintain this high quality care, we would like to share some facts about dental insurance with you.

Fact #1: Dental insurance is not meant to be a PAY-ALL. It is only meant to be an aid.

Fact #2: Many plans tell their insured that they'll be covered "up to 80%" or "up to 100%". In spite of what you're told, we've found most plans cover less than the average fee. Some plans pay more, some less. The amount your plan pays is determined by how much your employer paid for the plan. The less he paid for the insurance, the less you'll receive.

Fact #3: It has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying to them that "our benefits are low". Remember: you get back only what your employer puts in, less the profits and administrative costs of the insurance company.

Fact #4: Many routine dental services are *not* covered by insurance plans.

Please do not be hesitant in asking us any questions about our office policies. We want you to be comfortable in dealing with these matters, and we urge you to consult us if you have any questions regarding our services and/or fees. We will fill out and file insurance forms at no charge. We will do all we can to assure you of maximum benefits.

If we take assignment on your insurance, we feel that 60 days is a reasonable length of time for us to wait for payment from your insurance company. Thank you!