PATIENT INFORMATION UPDATE

(Please Print)

Date _____ Patient _____ Birthdate _____

Have there been changes in your address, telephone numbers, insurance or employment since your last visit? ☐ Yes ☐ No

Please specify _____

Special concerns for today's visit _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Phone (_____) _____ Pharmacy _____ Phone (_____) _____

AIDS	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	**Have you ever had or been diagnosed with:**	
Chemotherapy	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Artificial Joints, Screws, Pins, etc.	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Congenital Heart Lesions	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Special Diet/Weight Loss	☐ Yes ☐ No	Hernia Repair	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Hepatitis Type _____	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No		

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please describe _____

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If yes, please describe _____

Women: Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Have you ever taken any of these medications?

Blood Thinners	☐ Yes ☐ No
Coumadin	☐ Yes ☐ No
Warfarin	☐ Yes ☐ No
Diet Medications	☐ Yes ☐ No
Dexfenfluramine	☐ Yes ☐ No
Fen-phen	☐ Yes ☐ No
Pondimin	☐ Yes ☐ No
Redux	☐ Yes ☐ No
Levoxyl	☐ Yes ☐ No
Synthroid	☐ Yes ☐ No

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.
☐ Yes ☐ No

Are you allergic to:

Aspirin	☐ Yes ☐ No
Barbiturates	☐ Yes ☐ No
Codeine	☐ Yes ☐ No
Ibuprofen	☐ Yes ☐ No
Latex	☐ Yes ☐ No
Local Anesthesia	☐ Yes ☐ No
Metals (i.e. gold)	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No
Other _____	

Please PRINT all medications now taking: _____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

DOCTOR'S COMMENTS & UPDATE

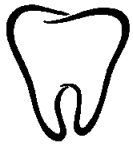
(to be completed by the dentist)

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____

Rev. 3/2012



Omni Dental Group • 4321 Collington Road • Suite 210 • Bowie, MD • 20716 • 301-809-0029

Insurance Submission Policy

Omni Dental Group understands that your dental policy may change during the course of the year. As a courtesy, we provide the services of billing and verifying your insurance coverage.

Omni Dental Group will submit to your Primary and Secondary insurances only. The submission of a third insurance is the responsibility of the patient.

The order of submission is determined by the insurance company. They decide which company is considered Primary and Secondary. We ask that you provide our office with any dental insurance changes you may obtain within **48 hrs.** of your next visit. If you do not provide your updated insurance information within the time period stated above, you will be required to pay out of pocket for your dental visit.

YOUR INSURANCE

If your insurance cannot be verified prior to your appointment, you will be responsible for all charges of the appointment. Utmost effort will be made to notify you of any such circumstances. Patients will be given a receipt for reimbursement from their carrier in circumstances where insurance cannot be verified.

In the event that your dental insurance or plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office or your next office visit, whichever should come first. If you disagree with the insurer's determination, you must contact your insurance company to resolve the dispute. Disputed charges shall not be adjusted on the Omni Dental Group account. The patient is responsible for all charges and any applicable finance charges.

ALTERNATE BENEFIT CLAUSE

Your insurance may contain clauses that affect the amounts paid by your insurance. Omni Dental will notify you of such clauses whenever possible; however, it is your responsibility, not Omni Dental Group's, to be aware of these clauses for your particular insurance and the effect on the amounts due. For example, an alternate benefit clause states that your insurance will only pay the cost of an amalgam filling, not a composite filling. Your responsibility for charges in this case would be the cost of the composite filling minus the cost the insurance will pay for an amalgam filling and your co-pay. You are responsible for the remaining difference.

By signing below, I acknowledge that I have read and understand the Insurance Submission Policy of Omni Dental Group.

_____ _____

Patient or Parent/Guardian Signature Date

Omni Dental Group

Cancellation/Broken Appointment Policy

We understand our patients' time is valuable and this is why we schedule appointments, so that the patient can arrange their schedules accordingly. We also ask for our patients to have courtesy of the office schedule in return by being on time for their appointments and rescheduling appointments in a timely manner.

All appointments are confirmed by phone with at least 48 hr. notice to the patient. The reminder call from our office is a courtesy to our patients. It is NOT mandatory. It is the patient's responsibility to know when their appointment is and to call us with reasonable notice if it is to be cancelled or changed.

If you need to cancel/reschedule your appointment, we kindly ask that you give us **48 hrs. notice for all appointments including the Specialist. If not confirmed after a courtesy reminder (via text, e-mail and call) and it is within 48 hrs. of your appointment, the appointment maybe considered cancelled and taken off the schedule. This may result in you not being seen on that day.** We will need that allocated time slot to accommodate another patient who is waiting for dental care.

Broken appointment fees are **$75** for Hygiene and General Dentist appointments and **$150** fee for the Specialist. This includes same day cancellations and no-shows.

If you are arriving more than 15 minutes late for your appointment, your appointment will be rescheduled for a later time.

Appointments considered to be missed/broken if either of the following occurs:

- The patient fails to appear for the appointment **(No Call or No Show).**
- The patient cancels or reschedules with less than **48 hrs.** notice.
- This includes same-day rescheduling.

After multiple broken appointments, we reserve the right not to make future appointments until all fees have been paid in full.

I acknowledge that I have been informed of cancellation/broken appointment fees. I have read and understand the above policy.

_____ _____

Patient or Parent/Guardian Signature **Date**