1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

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 dentist 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

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

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

5 HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

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

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name_____

Phone (_____)_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Welcome To Omni Dental Group

It is our goal to provide you with the most efficient, effective, and excellent dental treatment while also providing you with great customer service, common courtesy, and compassion to meet your personal dental needs. We need your help and understanding of your right to privacy, our financial policy, assignment of insurance benefits, and your responsibility in maintaining your oral health to achieve that goal. Please read the following carefully.

CONSENT FOR SERVICES

I authorize the Doctor to take x-rays, study models, photography, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis. I further authorize and consent that the Doctor may choose and employ such assistance he/she deems fit while making a diagnosis.

TREATMENT PLAN

After the initial comprehensive examination, we will discuss your oral health and recommended treatment plan with you. We will offer you treatment options where possible and plan treatment to address your most urgent needs first. In some cases, it is necessary to schedule urgent procedures prior to routine cleanings. The treatment plan can change during the process of actual treatment. Once your treatment is complete, we will monitor your general dental health at your 6 month recall (cleaning and exam) appointments.

It is your sole responsibility to maintain your oral health. We will assist you in any way possible to facilitate your treatment. However, if you do not comply with the planned and recommended treatment or otherwise fail to maintain your oral health, we will be unable to retain you as a patient in our practice.

MINOR PATIENTS

Omni Dental Group does not see patients under the age of 3 years old. An adult or guardian must accompany all minor patients (under the age of 18) and must remain on premises, outside the operatory, throughout the appointment. The parent or guardian accompanying the minor patient is legally responsible for any payments due at that appointment.

Omni Dental Group cannot provide child care during appointments and, as provided by state regulations, children cannot accompany an adult into the operatory. Please make arrangements for your children's care accordingly.

FINANCIAL POLICY

Payment for services is due at the time services are rendered. We accept cash, personal checks, most major Credit Cards, and Debit Cards. You may also qualify for interest free loans available through a third party lender upon credit approval. See www.carecredit.com or ask a Front Desk Associate for more information. Unfortunately, Omni Dental Group does not provide in office payment plans.

In the event of a returned check (NSF Item) an additional amount of **$35.00** (NSF Fee) will be charged. Payment of the amount of the NSF item plus **$35.00** NSF fee must be paid by cash, cashier's check, or money order.

In the event of default on any balance due, for any reason, the patient (or financially responsible party) will be accountable for any and all amounts due, finance charges, collection agency fees, attorney fees, and court costs.

PATIENT PRIVACTY NOTICE

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. The entire of Omni Dental Group values our relationship with you and we take personal privacy seriously. This privacy notice explains how we manage the personal and health information we have obtained from you and how that information is used in administering your dental insurance. Please read this notice carefully.

Information we collect about you: We collect nonpublic personal information about you or your family when you contact us to make a dental appointment. We require a copy of your insurance card when available. This personal information may include your name, address, telephone numbers, date of birth, Social Security number, and your employer information. We ask that you complete a comprehensive health history form for your personal record, and we require verification of your dental insurance for your specific plan coverage for you and all your dependents.

How your information is used: The personal and health information we obtain and store is used to effectively administrate your insurance benefits and to protect your health needs. Upon arrival you will sign your name on a sign in sheet. Your name may be called if you are needed at the front desk or if you are being taken to the treatment area. Your personal health information may be discussed with your physician or another healthcare provider. Your personal information may be requested by your insurance company to provide them information to properly file a claim. A laboratory may require some of your personal information, however, that is usually limited in nature.

Your treating dentist may discuss aspects of your case with one of his/her colleagues or information may be given to a specialist in order to provide treatment. The information you have provided to us may be used in the confirmation of appointments including messages left on answering machines and/or voice mail.

Safeguarding your personal and health information: We restrict access to your personal and health information to those employees who need to know the information to provide services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your personal and health information.

Changes to our privacy policy: Omni Dental Group occasionally reviews its privacy policy and reserves the right to amend it. Should our privacy practices change, we will post a copy of the revised Notice in our waiting area that indicates the date of the amended Notice. You may request and obtain a copy of our Notice of Privacy Practices anytime you visit our office.

Please initial each statement and sign below as acknowledgement and acceptance of these policies.

____ *I have read and understand the Patient Privacy Notice (HIPAA Notice) for Omni Dental Group.*
____ *I agree to consent to services as recommended by the Doctor.*
____ *I understand it is my responsibility to comply with the recommended treatment plan and to maintain my oral health. Failure to follow the recommended treatment plan may result in dismissal as a patient.*
____ *I have read and understand the financial policies of the practice and agree to be bound by the terms.*
____ *I certify that all information I provide is true and correct to the best of my knowledge.*
____ *I understand it is my responsibility to notify Omni Dental Group of any changes in pertinent information: insurance, address, phone numbers.*
____ *I understand any of these policies may be amended by the practice from time to time.*

_____ _____
Patient or Parent/Guardian Signature Date

□ Patient or Parent/Guardian Refusal to Sign. Reason: _____

Please return this form to the front desk. Thank you. ☺

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:

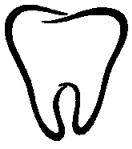
- The patient fails to appear for the appointment **(No Call or No Show).**
- The patient cancels or reschedules with less than **48 hrs.** notice.
- This includes same-day rescheduling.

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**



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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print patient name here

_____

Signature

_____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*