# OMEGA DENTAL, LLC

**General & Cosmetic Dentistry for Adults & Children**
**14551 W. Indian School Rd. Suite 200, Goodyear, AZ 85395**
**Tel: (623)535-8777  Fax (623)535-8776**
**www.omegadentalaz.com**


Who may we thank for referring you to our office? _____

## *Patient Information*

Patient name _____
*Last* *middle* *First*

Mailing address _____

City _____ State _____ Zip _____

Social Security #: _____ DOB: _____ Gender: _____

Home phone _____ Cell _____

Email: _____Marital Status _____

Occupation: _____ Employer _____

Emergency contact _____Relationship _____Phone: _____

## *Insurance Information*

**Primary insurance:**

Subsciber's name: _____ DOB: _____Group # _____

Social security #: _____ ID #: _____

Name of Insurance Company: _____ Phone #: _____

**Secondary insurance:**

Subscriber's name: _____ DOB: _____ Group #: _____

Name of Insurance Company: _____ Phone #: _____

# *Medical History*

1. Any major hospitalizations or gurgeries within the last two years? Yes or No

   Explain if Yes _____

   _____

2. Are you under the care of a physician ? Yes or No

   Name: _____

3. Are you taking any medications? Yes or No. Please list names and dosage or attach list

   _____

   _____

4. Do you have any of the following? Please mark and provide more information

| | | | |
|---|---|---|---|
| _ Diabetes | _ Arthritis | _ Heart burn | _ Snoring |
| _ Heart Disease | _ Ospeoporosis | _ Gastric reflux | _ Seasonal Allergies |
| _ Heart attack | _ Bone disease | _ Bleeding problems | _ Sinusitis |
| _ Heart Murmur | _ Artificial Valves | _ Taking blood thinner | _ Hepatitis |
| _ High blood pressure | _ Pregnant | _ Lung, Asthma | _ Tuberculosis |
| _ Pace maker | _ Breast feeding | _ Thyroid disease | _ HIV/ AIDS |
| _ Stents | _ Eye Problems | _ Cancer | _ Mental Illness |
| _ Stroke | _ Sleep apnea | _ Seizures | _ Alcoholism |
| | | _ Anxiety | _ Depression |

5. Conditions / syndroms / diagnosis not listed? Please explain _____

   _____

# *Dental History*

1. When was your last dental visit? _____
2. What treatment was performed at that time? _____
3. Have you ever been referred to a specialist? _____
4. Do you have missing teeth? _____
5. Have you ever had a deep cleaning? _____
6. What can we do to make your dental experience a pleasant one? _____

   _____

# *Omega Dental Office Policy*

Welcome to OMEGA DENTAL. We are here to provide our patients with the best possible dental care. As your provider, we recommend treatment that is in the best interest of your medical and dental health. Be aware that insurance companies select certain dental procedures that they may or may not cover regardless of your personal situation, health, and dental needs. The following is an overview of our office financial policy.

***Insurance***: Dental Insurance rarely pays for 100% of all dental services. As a courtesy, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement.

**Initials_____**

Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays.

**Initials_____**

***Payment***: Payment is required at the time of service. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, MasterCard and Discover. Our office also offers no interest and extended payment plans, upon approved credit, through CareCredit.

**Initials_____**

***Estimates***: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary.

**Initials_____**

***Aged Account***: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in OMEGA DENTAL being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs.

**Initials_____**

***Appointments***: If you are unable to keep a scheduled appointment, we ask that you provide us with 48-hour notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of $100.00. We understand emergencies arise; we are sensitive to those events.

**Initials_____**

***Assignment of Benefit***: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to OMEGA DENTAL Dental.

**Signature of Person Responsible for Account**

_____ _____

Date

**Printed Name of Person Responsible for Account**

_____

# *Letter of Consent*

1. I, hereby, authorize and direct the dentist(s) of OMEGA DENTAL and / or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (Xrays), or diagnostic aids.

    - ♦ Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
    - ♦ Application of plastic "sealants" to the groves of the teeth
    - ♦ Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
    - ♦ Replacement of missing teeth with dental prostheses (bridges, partial dentures, full crowns).
    - ♦ Removal (extractions) of one or more teeth.
    - ♦ Treatment of diseased or injured oral tissues (hard and/or soft).
    - ♦ Treatment of malposed (crooked) teeth and/or oral development 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. That I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of a local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, physical restraints or voice control depending on the judgment of the doctor(s). Nitrous oxide/oxygen my occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indention or ring around the nose which disappears shortly after the procedure. I understand and have informed of the above risk and complications.
4. I recognize that during the course of the treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional or different procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
5. These 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 ulcerations and infections 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 breath and heart function) and the lack of oxygen to the brain that cardiovascular collapse (stopping of breathing and heart function) and the lack of oxygen to the brain that could cause coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctors to use photographs, radiographs, and other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publications.
7. I will be advised that the success of the dental treatment to be provided will be required 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 must be maintained.
8. 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.
9. I further understand that this consent will remain in effect until such time that I chose to terminate it.

_____ _____

Date

**Signature of Patient or Parent or Guardian**