CENTRAL DENTIST
HOLISTIC DENTISTRY & FUNCTIONAL ORAL HEALTH

Jill Ombrello
DDS, AIAOMT, AIABDM, CIFM

New Patient Registration Information - Child Date: / /
Please complete the following confidential information

Name: ____ Date of Birth: _______________ Age: ________
LAST FIRST M.I.

I prefer to be called: ___________________ You were referred to us by: ______________________________

Address:____
STREET CITY STATE & ZIP

Phone No..:________________|______________________|_____________________|____________________
HOME CELL WORK OTHER

Sex: _________ Height: _________ Weight:_________ Grade: ________

School:_______________________

Hobbies/Activities: ____

__________________________________ ____
Mom's Name and Email Dad's Name and Email

Is another family member or relative a patient at our office? ____
NAME RELATIONSHIP

Referring Physician: ___________________________ Primary Physician: ___________________________

Dental Ins. Co.:______________ Ins.Phone #:____________________ Subscriber's Employer______________

Subscriber Name:__________________________ Subscriber ID or Social:____________________________

Group ID:________________ Subscriber DOB:__________Relationship to Patient:____________________

CENTRAL DENTIST
HOLISTIC DENTISTRY & FUNCTIONAL ORAL HEALTH

Jill Ombrello
DDS, AIAOMT, AIABDM, CIFM

Health History

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia ❑ Cancer ❑ Epilepsy ❑ Down syndrome ❑ Mononucleosis
❑ Asthma ❑ Cerebral Palsy ❑ Fainting ❑ Mumps ❑ Rheumatic fever
❑ Autism/Adhd ❑ Chicken Pox ❑ Growth Problems ❑ Kidney disease ❑ Speech Delay
❑ Bladder weakness ❑ Chronic Sinusitis ❑ Hearing ❑ Latex allergy ❑ Seizures
❑ Bleeding disorders ❑ Diabetes ❑ Heart disease ❑ Liver disease ❑ Seasonal allergies
❑ Bones/Joints disorder ❑ Ear Aches ❑ Hepatitis ❑ Measles
❑ Development delay ❑Other

Child's History **Yes** **No**

1. Is the child taking any prescription/ over the counter medications or vitamins at this time? ❑ ❑
   If yes please explain____
2. Is the child allergic to any medications? ______________________ ❑ ❑
3. Has the child had any serious illness? ________________________________ ❑ ❑
4. Does the child have any speech difficulties? _____________________________ ❑ ❑
5. Is the child physically, mentally, emotionally impaired? ❑ ❑
6. Is this the child's first visit to dentist? If not last dental visit ___/____/____ ❑ ❑
7. Has the child ever had any problems with dental treatment in the past? ❑ ❑
8. Has the child suffered any injuries to the mouth, head or teeth? ❑ ❑
9. Has the child had any problems with the eruption of teeth? ❑ ❑
10. Has the child had any orthodontic treatment? ❑ ❑
11. What type of water does your child drink ❑ City water ❑well water ❑bottled ❑filtered?
12. Is fluoride toothpaste used? ❑ ❑
13. How many times are the child's teeth brushed per day? _________________
14. Does the child suck his/her thumb? ❑ ❑
15. Does the child have any food allergies? ______________________ ❑ ❑

Any other health problems not listed above

____
____

____________________ __/__/__ ___________________________
Guardian Signature **Date** **Patient Name**

Jill Ombrello
DDS, AIAOMT, AIABDM, CIFM

Pediatric Functional Health & Wellness Assessment

Unless otherwise noted, please use the scale below to indicate the severity of each of the symptoms listed:

0 Not Present   1-2 Mild   3 Moderate   4-5 Pronounced

Airway Health

Related to your child's snoring, please check all that apply:
( ) Snores only when sick or congested
( ) Snore only infrequently (1 night/wk)
( ) Snore fairly often (2-4 nights/wk)
( ) Snore habitually (5-7 nights/wk)
( ) Snores in any position
( ) Snores only when positioned on back

___ Have labored, difficult, loud breathing at night
___ Have interrupted snoring where breathing stops for 4 or more seconds
___ Have stoppage of breathing more than 2x/hr
___ Mouth breathes during the day
___ Mouth breathes while asleep
___ Wakes up with a runny or congested nose
___ Sucking habit (thumb/finger, pacifier, tshirt, etc)

Speech

___ Is it difficult to understand your child's speech?
___ Difficult to understand over the phone?
___ Nasal speech?
___ Speech sounds abnormal?
___ Others have difficulty understanding speech?
___ Gets frustrated when people can't understand speech?
___ Sometimes omits consonants?
___ Uses M, N, NG, instead of P, F, V, S, Z sounds
__Hoarseness
__Lisp
__Any speech therapy? If so, for how long? ___

Neurocognitive Conditions

___ Hyperactive and/or attention deficit
___ Poor ability or difficulty in school
___ Have a hard time listening &/or often interrupts

Sleep Habits

___ Grinds teeth
___ Frequent morning headaches
___ Night sweats, or excessive sweating while sleeping
___ Talks in sleep
___ Wakes up at night
___ Restless or "active" sleep with significant movement
___ Dark circles or "venous pooling" under the eyes
___ Feels sleepy and/or irritable during the day
___Ever wets the bed
___Bluish color at night or during the day

Immunity

___ Frequent throat infections
___ Frequent sickness (ie. cold, flu, fever, etc)
___ Allergic symptoms
If applicable, please check any remedies that have been used to treat allergies:
( ) Nasal lavage/ Netty Pot
( ) Nose spray
( ) Medication, Over the counter ( ), Prescription ( )
( ) Allergy testing, Allergy Shots ( )
( ) Dietary changes

Nutrition & Oral Hygiene

Times per week your child has sugar ___
Times per week your child has non-water beverage (ie. juice, milk, soda, etc) ___
How often does your child brush his/her teeth? _____
Check any other components of a hygiene program that your child uses consistently:
( ) Plaque tablets ( ) Floss ( ) Mouth rinse
( ) Tongue cleaner ( ) Fluoride supplements
With whom does your child brush his/her teeth:
( ) Alone ( ) With parents ( ) Siblings
( ) Other family member, nanny

"It is easier to build strong children than to repair broken men." – Frederick Douglass

CENTRAL DENTIST
HOLISTIC DENTISTRY & FUNCTIONAL ORAL HEALTH

Jill Ombrello
DDS, AIAOMT, AIABDM, CIFM

Informed Patient Consent

Patient Name ____DOB___________________________

The entire Central Dentist team welcomes you! We would like to give you a little more information about ourselves, and what to expect during our sleep apnea testing & treatment process. This document contains important information about our professional services and business policies. Please read it carefully, and if you have any questions, we can discuss them together prior to starting the sleep apnea testing and treatment process. When you sign this document, it will represent an agreement between us.

CONFIDENTIALITY AND PRIVACY NOTICE:
Privacy is a very important concern for all those who use our services. In general, the privacy of all communications between a patient and a physician is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

We may need to release basic diagnostic and clinical information to your insurance provider in order to obtain treatment authorization or to get claims paid. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings, a judge may order our testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect you or others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency, or if we believe that a patient is threatening serious bodily harm to another. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have together. If you need specific advice, please be aware that formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

I have read and discussed the above agreement. I understand and agree to all of the points discussed above. If at any point I have questions or problems regarding my treatment, I understand how to contact the practice, and receive support for my individual needs. I am providing consent for treatment to include, home sleep testing, diagnostic scans (such as X-ray or Cone Beam CT), and related sleep apnea treatment devices- if sleep disordered breathing is diagnosed.

IN CASE OF EMERGENCY, PLEASE CONTACT CENTRAL DENTIST AT 214.368.0900

____________________________________ ______________________________ ______________

Guardian Signature Guardian Printed Name Date

CENTRAL DENTIST
HOLISTIC DENTISTRY & FUNCTIONAL ORAL HEALTH

Jill Ombrello
DDS, AIAOMT, AIABDM, CIFM

Patient Name: ____
Last First MI Maiden or Other Name

Date of birth: ____/_____/_____ Phone Number: ___________________________________

Address: ___________________________City: _______________State: ______Zip:__________

I grant / DO NOT grant Dr.____________________________ and his/her practice permission to take and use photographs and digital images of me for the purpose of:

- ☐ **Teaching (i.e. Educational materials)**
- ☐ **Marketing (i.e. Web site, brochures, etc.)**
- ☐ **Other: ____**

This request and authorization applies to photography or digital images taken on:

____
Date(s) of image capture

I understand that once my photograph(s) or digital image(s) have been released, Dr. ___________________ and his/her practice may no longer have control over them, and federal or state privacy laws may no longer protect the information that was released.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already used my photograph(s) or digital image(s) prior to me canceling this authorization, which would not prohibit any release done prior to the date of cancelation.

To cancel this agreement, I must write a letter to the doctor or practice advising of my wish to cancel my authorization to release photograph(s) or digital image(s) taken of me by this practice. I (or my authorized representative) must sign and date the letter.

If this authorization has not been canceled, it will expire ________ days after the date signed.

___________________________ ________________________
Patient Signature/Legal representative Date

____
Relationship of legal representative

CENTRAL DENTIST
HOLISTIC DENTISTRY & FUNCTIONAL ORAL HEALTH

Jill Ombrello
DDS, AIAOMT, AIABDM, CIFM

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: ____

Last First MI Maiden or Other Name

Date of Birth: ___-____-____ Medical Record #:____________ Phone: _________________

Address: ___________________________City: ______________State: _____Zip:_______

Date of Service: ____

□ **I authorize** Dr.______________ to use and disclose my protected health information for his/her own purposes of treatment, payment, and health care operations.

□ **I authorize** Dr. ____________________ to disclose the following records related to the date above:

□ **I DO NOT authorize** Dr. ____________________ to disclose the following records related to the date above:

Records: □ All records
□ Medical Records
□ Diagnostic Records (lab, x-ray, etc.)
□ Treatment Records
□ Billing/Claims Records
□ HIV/STD
□ Drug and alcohol related

Please release these records to:

Name: ____

Address: ____

City:_____________________ State:________ Zip Code :____________

Phone: (___)_______________Fax:__________________ Email: _______________________

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request, and no longer protected by these regulations.

You may **revoke this authorization** in writing at any time by sending written notification to:

Dr. Jill Ombrello Fax: 214.225.6345
Email: info@centraldentist.com

Please note: Revocations do not apply to information that has already been disclosed prior to revocation being received.

You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity.

You have the right to receive a copy of this authorization. This authorization expires one year from date of signing or on _____________________________

____________________________ __________

Patient or Legal Representative Signature Date:____

Print patient or Legal Representative Name/Relationship ____

CENTRAL DENTIST
HOLISTIC DENTISTRY & FUNCTIONAL ORAL HEALTH

Jill Ombrello
DDS, AIAOMT, AIABDM, CIFM

Dental Patient Policies Form

Thank you for choosing Central Dentist, for your dental care. Our primary goal is to provide thorough dental care in a comfortable, relaxed environment. To ensure a long lasting and well-informed relationship we have listed our policies as they concern you. Please read through the following policy information and sign where indicated. Should you have any questions, please do not hesitate to ask one of our team members. Thank you.

Financial Policy

REGARDING INSURANCE

We are a zero-balance practice, which means patients pay in advance for treatment recommended by the doctors before treatment reservations are made. As a courtesy to our patients, our office will file insurance for dental procedures upon receipt of necessary insurance information. This is a service that we provide, but please remember that you have a contract with your insurance company and are responsible for payment. We cannot accept responsibility for collecting from your insurance company nor negotiating a settlement on the disputed claim. However, our insurance coordinator is available if you have any questions. Remember, you are the holder of the contract. It is your responsibility to make sure you understand the contract between you and your insurance company, and you know your benefits for the policy. This is not our responsibility. Central Dentist does not guarantee payment or coverage by your insurance policy provider.

CANCELLATION POLICY

When you have a reservation to see a provider, we require a 48-Hour notice of appointment cancellation. If you have a confirmed appointment and fail to cancel, you will be billed a fee for that reserved appointment time. Deposits made for treatment appointments are non-refundable. All appointments do require confirmation via text or phone call.

PAYMENTS

Upon completion of your dental appointment, our team will provide a walkout statement of your account outlining the fees for the dental investment made that day. All fees for the services provided are due at the time services were rendered. We accept cash, check, all major credit cards, and care credit. Care Credit charges must be a minimum investment of $1,500. Any charge below $1,500 are subject to an 8% service fee. If we receive a check returned to us for insufficient funds, the following will occur: 1. A $45.00 charge will be applied to your account. 2. You must clear the account promptly by paying with cash, certified check, money order or credit/debit card. 3. Your privilege of writing checks in our office will be jeopardy.

PAST DUE ACCOUNTS

Open accounts with no acceptable payment activity for 30 days will be mailed a statement and considered past due. We will give you, the patient, a statement of that includes the services and fees rendered on the date of you received treatment.

COLLECTIONS

Open accounts with no acceptable payment activity or patient contact for 60 days will be considered delinquent and will be turned over to our collection agency. You will be responsible for the original past due balance, along with additional charges.

Patient/Guardian Signature______________________________ **Date:**____________________

CENTRAL DENTIST
HOLISTIC DENTISTRY & FUNCTIONAL ORAL HEALTH

Jill Ombrello
DDS, AIAOMT, AIABDM, CIFM

Scheduling Policy

Rescheduling or Canceling Appointments- The office requires that you inform us if you need to reschedule or cancel at least 48 hrs. prior to that appointment. We accept cancellations on the answering machine or email.

Appointment Confirmation- We will attempt to reach you by using our automated reminder system, email, text message or telephone prior to your appointment. We ask that you please reply in some form to let us know you will be making your scheduled appointment. If we have not received confirmation 24 hrs prior to your appointment time, we reserve the right to give your treatment time to another patient.

Missed and Late Appointments- Your appointment time has been reserved especially for you at exclusion of others who may be waiting for an appointment. If you miss your appointment and we do not receive at least 48hrs prior notice there will be a cancellation or No-Show fee with a minimum $75 charge for a hygiene appointment and $150 for a treatment appointment which includes SRP (Deep Cleaning), Fillings, Crowns, etc.

If you arrive more than 15 minutes late, we will not be able to see you for that appointment.

I HAVE READ AND AGREE TO ALL POLICIES

_________________________________ _____________________________

Patient/Guardian Signature DATE