Dr. Jill Ombrello
AIAOMT, AIABDM, CIFM

New Patient Registration Information -Adult

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

Social Security#: _______________________ Email:____

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

Emergency Contact: ____
NAME CONTACT NUMBER

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

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Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: ____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: ____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? ______________________________ Date of last physical exam ___/____/_______
Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?____
Have you ever had surgery? Yes No
If yes, when and what for? Date of surgery:__________ Reason for surgery:_____________
Date of surgery:__________ Reason for surgery:_____________

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)? Yes No

Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)? Yes No

Kidney disease or kidney failure, requiring dialysis? Yes No

Thyroid disease? Yes No

Stomach ulcers or colitis? Yes No

Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth? Yes No

Frequent or recurring mouth sores? Yes No

Glaucoma? Yes No

Diabetes? Yes No

Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Yes No

Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily? Yes No

Liver disease (jaundice, hepatitis A, B, or C)? Yes No

Arthritis? Yes No

Significant weight loss or gain? Yes No

Seizures, convulsions, epilepsy, fainting or dizziness? Yes No

Sinus or nasal problems? Yes No

Sleep apnea? Yes No

Osteoporosis or osteopenia? Yes No

Any cancer, radiation, or chemotherapy? Yes No
Describe: ___________________________Date of your last treatment? ______________

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: ____

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FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes? Yes No Relationship ____________

Cancer? Yes No Relationship ___________

Heart disease? Yes No Relationship ____________

Bleeding problems? Yes No Relationship ___________

Tumors? Yes No Relationship ____________

Lung disease? Yes No Relationship __________

Sleep Apnea? Yes No Relationship ____________

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS

Are you using any of the following:

Antibiotics? Yes No

Anticoagulants (blood thinners)? Yes No

Heart medications? Yes No

Steroids (cortisone, prednisone, etc.)? Yes No

Antianxiety agents, antidepressants or other psychiatric medications? Yes No

Prescription pain medication? Yes No

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Yes No

Insulin or oral anti-diabetic drugs? Yes No

Blood pressure medications? Yes No

Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. Yes No

____

____

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	**Dosage**	**Medication**	**Dosage**

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex? Yes No

Food products? Yes No

Sedatives, barbiturates? Yes No

Codeine or other pain killers? Yes No

Aspirin, Motrin, Aleve, or ibuprofen? Yes No

Penicillin or other antibiotics? Yes No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _______________ Relationship? __________________

Other drug or food allergies not listed above:

____

____

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SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No — If yes, for how long? ____________________

Have you ever sought professional care or been hospitalized for:

Substance abuse? Yes No
Emotional disorders? Yes No
Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? ________
Marijuana? Yes No How often? ________
Recreational drugs? Yes No How often? ________

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?____________________
____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

______________________________ ______________________
Signature of patient, parent, guardian Date

______________________________ ______________________
Printed name of patient, parent, guardian/Relationship Doctor's Signature

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 'just tired'? This refers to your usual way of life at present and in the recent past. Even if you have not done some of those things recently, try to work out how they would have affected you.

0 = would never doze 1 = slight chance of dozing 2= moderate chance of dozing 3 = high chance of dozing

____ Sitting and reading
____ Watching television
____ Sitting, inactive in a public place (e.g. theatre, meeting)
____ As a passenger in a car for an hour without a break
____ Lying down to rest in the afternoon when circumstances permit
____ Sitting and talking to someone
____ Sitting quietly after lunch without alcohol
____ In a car, while stopped for a few minutes in traffic
____ **TOTAL SCORE**

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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
□ HIV/STD
□ Drug and alcohol related
□ Billing/Claims Records

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

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CENTRAL DENTIST

Patient Photography Release Form

Patient Name: ____
Last First MI Maiden or Other Name

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

Address: ______________________City: __________State: _____Zip:________

I do 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: ____**

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

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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. When booking a treatment service, including deep cleanings, we require payment to reserve treatment time. We accept cash, check, all major credit cards, and care credit. Care Credit charges must be a minimum investment of $1,500. 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 in 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 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:**________________________

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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

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Oral Cancer Screening Consent Form

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the Oral ID screening device into our office. The Oral ID examination will aid in visualization of oral mucosal abnormalities, such as cancer and pre-cancer. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of oral cancer is critical. If oral cancer is detected in its later stages, which typically only occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at risk?

- Age 17+ years
- Tobacco use
- Alcohol use
- HPV infection
- Previous history of cancer

If you have any questions about risk factors, please feel free to talk to a Central Dentist doctor, hygienist or assistant. We recommend all patients be screened with the Oral ID.

Our office charges $77 per screening with the Oral ID. We will submit a claim on your behalf to your insurance for potential reimbursement; however, we cannot guarantee this is a covered benefit with your specific policy.

_______ Yes, I request that your staff perform an examination with the Oral ID. I accept financial responsibility for this examination.

_____________________ ________________________ __________
Signature Printed Name Date

_______ No, I prefer NOT to have this examination at this visit.

__________________________________ ________________________ __________
Signature Printed Name Date