CENTRAL DENTIST

Introduction to Our Practice & What to Expect from Your First Visit

If you're reading this, then that most likely means that you are considering our doctors and our practice as your new provider. We thank you for the opportunity to introduce ourselves. We have provided answers to what we believe to be some important questions, but feel free to reach out to anyone on our team via the contact information listed below to inquire further.

First things first, what's our "why"?

It's important that you, a potential patient, know that we choose to view our primary role as "doctor" means for us to serve as an educator. We recognize that you come to us because we have the advanced education, training, experience, and knowledge of ongoing research to help inform and guide you on your path to restoring and/or maintaining optimal oral and systemic health. We are also aware of the present- day burden on patients to sift through all of the information from other doctors, online, and from friends and family. Beyond that, we know that typically once a patient has started to seek out alternative therapies (such as ours), you've already spent a great deal of time and money on the *wrong* approaches to your health or "solutions" to your ailments. As such, we would like to make this first step as easy as possible for you so you can more swiftly work towards better understanding your oral health and its relation to your systemic wellness.

What to expect from my first visit?

The first visit to our office includes a comprehensive review including the collection all of your diagnostic records (listed below). This first appointment takes about 90 min, and while the doctor will make time to review the information with you immediately after that, we may recommend additional testing prior to finalizing our treatment recommendations. Since we are doing such a deep review of all of your historic and present-day health history and concerns, and there is so much to evaluate between the oral-systemic health link, we know that we are able to provide better information with that additional review time.

What specific diagnostic records will be taken at my first visit?

- **First, we ask that you submit your paperwork 48 hours prior to your visit, or come to this first visit with it already completed 30 minutes prior to your appointment time.**
- CBCT for 3D scan of head and neck to identify hard and soft tissue pathologies, airway diameter, sinus and nasal health, and TMJ (if interested on this, more info can be found here)
- Digital panoramic & intra-oral radiographs for dental examination of historic dental work and existing disease/health state
- Clinical intra-oral photos - for documentation and easier patient education
- Digital occlusal scan to evaluate stress fractures, imbalances in dynamic function of the jaws
- Detailed questionnaires related to dental and systemic health history, sleep health, presentation of symptoms
- Review of and counsel on nutrition, hydration, oral hygiene habits and products used in the mouth and on the head and neck
- Head and neck visual cancer screening and counsel on ongoing cancer prevention
- Also, we welcome you to send any additional lab tests, reports, etc. from any other healthcare provider you may see including but not limited to your primary care physician, physical/occupational/speech/myofunctional therapist, nutritionist, etc. ; this can be sent prior to or after your initial diagnostic records visit

Pending any additional needs, we will sometimes suggest further diagnostic records that may include, but are not limited to:

- Saliva testing to identify strains of bacteria present in patients with active periodontal disease or decay

- Home sleep test for patients with symptoms of sleep-disordered breathing or have been diagnosed with sleep apnea
- Mercury tri-test for patients planning to have mercury amalgam fillings removed
- Dental material sensitivity/allergy test for patients with existing treatment and/or are in need of treatment and have history of sensitivity to materials
- Joint vibrational test for patients with TMJ disorder

When you return for your doctor consult, we will do a brief clinical exam in the dental chair, and then spend the remainder of our time discussing the findings and suggestions to restore and/or maintain optimal oral health and systemic wellness. This appointment typically takes anywhere from 30 min-1 hr.

We hope this helps make your decision to join our practice that much easier. If not, please reach out to us at your convenience. Otherwise, we look forward to meeting you soon!

Warmest Regards,

Jill Ombrello, DDS, AIAOMT, AIABDM, CIFM
Holistic Family Dentist, Special Needs Patient Advocate

"The doctor of the future will give no medication but will interest [her] patients in the care of the human frame, diet, and in the cause and prevention of disease." – Thomas A. Edison info@centraldentist.com | 214-368-09

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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 _____

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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	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	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 not listed above that you think the doctor should know about? Yes No

If yes, please explain: _____

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	Prescription pain medication?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric 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**
Medication	**Dosage**	**Medication**	**Dosage**

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ALLERGIES

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

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	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:

_____

_____

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:			**Do you use:**		
Substance abuse?	Yes	No	Alcohol?	Yes	No
Emotional disorders?	Yes	No	Marijuana?	Yes	No
Alcoholism?	Yes	No	Recreational drugs?	Yes	No

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

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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 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 ☐ _HIV/STD

☐ _Diagnostic Records (lab, x-ray, etc.) ☐ _Drug and alcohol related

☐ _Treatment Records ☐ _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

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-BUSINESS 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 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 10 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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