



We are delighted to welcome you to our practice and thank you for choosing us as your dental team. We strive to provide our patients with the highest quality dentistry tailored to the patient's desires in a warm and caring environment.

We are committed to excellence and providing you the best dental care at reasonable fees. Our goal is to help you have a beautiful, healthy smile that makes you feel and look great.

We believe that every patient deserves information and the choices they have in dentistry today to achieve their lifetime strategy for dental health. The way we begin that care is to provide a comprehensive evaluation.

During your first appointment, a thorough oral evaluation will be completed. This will include radiographs and other diagnostic aids necessary to determine indicated dental treatment. Radiographs are an extremely important part of this comprehensive evaluation, without them, a proper diagnosis cannot be made. If you have been to another dental provider within the last year and radiographs were taken, we ask you to bring these current x-rays with you to your initial appointment. Please do not mail them. If you do not bring them, or they are not of adequate quality, new radiographs will be taken at the initial appointment in order to provide you with a proper diagnosis.

After your comprehensive evaluation, you will receive a thorough explanation of our diagnostic findings and then we may reserve time for a personalized consultation to discuss your treatment options as necessary. We will work with you to reserve any necessary appointments and make appropriate financial arrangements.

Enclosed is our patient profile, dental and medical history forms. Please complete them prior to your appointment, and email, fax, or bring them to the office with you. Your answers will assist us in satisfying your specific dental wants and needs.

If you have any questions, please call us at one of the phone numbers listed below. We look forward to meeting you at your appointment.

Thank you again for choosing our dental practice.

Sincerely,

Your Omni Dental Team

www.OmniDentalCentre.com

1026 Woodbury Ave
Council Bluffs, IA 51503
712-328-8573

3004 N 13th St
Carter Lake, IA 51510
712-347-6151

Our Team's Mission at Omni Dental is to effectively communicate with our patients in order to understand their wishes and desires and to provide ongoing education to optimize their overall health and well being. We will then offer extraordinary, comprehensive dental care in a professional environment which meets the diverse, individualized needs of our patients.

Patient Information

SS#/SIN _____
Date of Birth _____

Name _____ Preferred Name _____
(Last) (First) (MI) City State Zip
Address _____
Home phone _____ Cell phone _____ E-mail _____

How did you hear about our office? _____

Check Appropriate Boxes: Minor Single Married Divorced Widowed Separated Male Female
If Student, Name of School/College _____ City _____ State _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Dept _____ Work phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party (if other than above)

Name of Person Responsible for this Account _____ Relationship To Patient _____
Address _____ City _____ State _____ Zip _____
Home phone _____ Cell phone _____ E-mail _____
Driver's License # _____ Date of Birth _____ SS#/SIN _____
Employer _____ Work Phone _____
Is this Person Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured _____ Relationship To Patient _____
Date of Birth _____ SS#/SIN _____
Name of Employer _____ Dept _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Dental Insurance Company _____ Group # _____ Policy/ID # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No

IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship To Patient _____
Date of Birth _____ SS#/SIN _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Dental Insurance Company _____ Group # _____ Policy/ID # _____

Please continue with update on reverse side of form

Medical History

Name _____ Preferred Name: _____
 (Last) (First) (MI)

Physician _____ Office Phone _____ Date of Last Medical Exam _____

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Are you under medical treatment now?..... | <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you allergic to or have you had any reactions to the following?..... | | |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.....
If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (e.g. Novocain)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you take any medications for prevention of Osteoporosis? (Fosamax, Boniva, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other Antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any joint replacements?.....
If yes, which joint and when? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a persistent cough or throat clearing not associated with a known illness (last more than 3 weeks)?..... | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken Fen-Phen/Redux?..... | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use tobacco?..... | <input type="checkbox"/> | <input type="checkbox"/> | Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you use or have you used controlled substances?..... | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any Metals (e.g. nickel, mercury, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other including any foods (please list) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 10. Women Only: | | |
| | | | a) Are you pregnant or think you may be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b) Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c) Are you taking oral contraceptives?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please list all medications you are currently taking including non-prescription: _____

Do you have or have you had any of the following?

- | | YES | NO | | YES | NO | | YES | NO |
|----------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| Heart Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> | Asthma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack..... | <input type="checkbox"/> | <input type="checkbox"/> | Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> | Fainting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy..... | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever..... | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy..... | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy / Convulsions..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse..... | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problem..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur..... | <input type="checkbox"/> | <input type="checkbox"/> | Anemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV Infection..... | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Bypass Surgery..... | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina / Chest Pain..... | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Trouble / Ulcers..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke..... | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis..... | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever / Allergies..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles..... | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression/anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Problems..... | <input type="checkbox"/> | <input type="checkbox"/> | Recent weight loss..... | <input type="checkbox"/> | <input type="checkbox"/> | Other..... | | |

Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

Please state any dental concerns you have: _____

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing?..... | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods?..... | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods?..... | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? Oral surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries?..... | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Do you wear dentures or partials?.....
If yes, date of placement _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking?..... | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face)?..... | <input type="checkbox"/> | <input type="checkbox"/> | 17. Would you like to change anything?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Difficulty in chewing?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. *I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

X

Signature of Patient (or parent/guardian if minor)

Date

Omni's Smile and Sleep Evaluation...

Name _____ Date _____

1. Do you like the way your teeth look? Yes No

Explain: _____

2. Would you like for your teeth to be whiter? Yes No

Explain: _____

3. Would you like your teeth to be straighter? Yes No

Explain: _____

4. Do you have spaces between your teeth that you would like closed? Yes No

If so, where? _____

5. Do you have missing teeth that you would like to replace? Yes No

Explain: _____

6. Do you have old silver fillings that you would like to replace with tooth-colored fillings?
Yes No

Explain: _____

7. If you could change anything about your smile, what would you change?

8. Do you snore? Yes No

9. Have you ever been diagnosed with sleep apnea? Yes No

10. Do you wear any type of C-PAP machine, or other apnea appliance? Yes No

11. How many hours of sleep do you get a night? _____.

Do you wake feeling rested? Yes No



James R. Knott, D.D.S.
David L. Jones, D.D.S.
Robert W. Hurley, D.D.S.

Melissa A. Nensel, D.D.S. Associate

Grant J. Flenker, D.D.S. Independent Contractor

Due to feedback we have received, we believe that we need to make some modifications to the changes we were going to implement in our financial update. This letter includes our revised version. We will not be storing payment information.

As a valued member of our Omni Dental family, we would like to inform you of our Financial Update for 2015. We are committed to focus on your exceptional dental health. The cost of billing services has increased dramatically and we would prefer to keep those increases from being passed on to you. Therefore, the following changes to payment for all services, including hygiene appointments, will be implemented at your next time in our practice.

From this point forward, we will ALWAYS provide you with a financial arrangement for all proposed treatment which will require your signature to be sure you understand the need for treatment and your financial responsibility.

If you are a patient that has dental insurance benefits, we will continue to submit insurance claims to your carrier for reimbursement for services provided to you and we will be asking, at each visit, for a copy of your insurance card. Prior to your arrival we will do our best to **estimate** your portion of payment. We will collect your **estimated** portion at the time of your appointment. Please be prepared to satisfy your financial responsibility at that time. If your insurance company chooses not to pay for your treatment **you will be responsible for the remaining balance.**

You can make your payments with any of the methods below:

Cash: This includes money orders, personal checks and cashier checks.

Bank Cards: Cards accepted include MasterCard, Visa, American Express and Discover.

Healthcare Financing: Care Credit Healthcare Financing, a program which allows you to pay as little as 3% of your balance per month.

These changes to our payment arrangements are necessary to continue to provide all of our patients the best possible dental care. We thank you for allowing us to take care of you, your family, and friends. If you have any questions, please feel free to give us a call. We look forward to seeing you at your next visit

Continue on in good dental health,
The Team of Omni Dental

Patient/Guarantor Name: _____ Date: _____

Signature: _____

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Council Bluffs, IA 51503
712-328-8573

3004 N 13th St
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Patient HIPAA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Staying within the “reasonable” guidelines of HIPAA, I give permission for Omni Dental to discuss my dental care and related issues with the following persons, in addition to myself. If none, please state so:

Name:

Relationship:

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of Omni Dental and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedures(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
 - A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
 - B. Application of plastic “sealants” to the grooves of the teeth.
 - C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
 - D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures).
 - E. Removal (extraction) of one or more teeth.
 - F. Treatment of diseased or injured oral tissues (hard and/or soft).
 - G. Use of sedative drugs to control apprehension.
 - H. Treatment of malposed (crooked) teeth and/or oral developmental 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 and that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
4. There 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 ulceration and infection 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 breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
5. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
6. I will be advised that the success of the dental treatment to be provided will require 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 and his/her auxiliaries must be maintained.
7. 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.
8. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____

Patient Name: _____

Name of Parent or Guardian: _____

Signature of Patient or Parent or Guardian: _____



Facts Regarding Dental Insurance

Dental insurance is rapidly playing a larger role in helping people obtain dental treatment. Since we strongly feel that our patients deserve the best possible dental care we can provide, and in an effort to maintain this high quality care, we would like to share some facts about dental insurance with you.

- Fact #1:** Dental insurance is not meant to be a PAY-ALL. It is only meant to be an aid.
- Fact #2:** Many plans tell their insured that they'll be covered "up to 80%" or "up to 100%". In spite of what you're told, we've found most plans cover less than the average fee. Some plans pay more, some less. The amount your plan pays is determined by how much your employer paid for the plan. The less he paid for the insurance, the less you'll receive.
- Fact #3:** It has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying to them that "our benefits are low". Remember: you get back only what your employer puts in, less the profits and administrative costs of the insurance company.
- Fact #4:** Many routine dental services are *not* covered by insurance plans.

Please do not be hesitant in asking us any questions about our office policies. We want you to be comfortable in dealing with these matters, and we urge you to consult us if you have any questions regarding our services and/or fees. We will fill out and file insurance forms at no charge. We will do all we can to assure you of maximum benefits.

If we take assignment on your insurance, we feel that 60 days is a reasonable length of time for us to wait for payment from your insurance company. Thank you!