10020 Dupont Circle Ct, St 150
Fort Wayne, IN 46825
260-203-4920

Omni Dental Patient Registration

Patient's Name _____ MI_____ Preferred Name _____ Gender _____

Date of Birth_____ SS#_____ Marital Status _____

Preferred phone number_____ Work number_____ E-mail _____

Address _____ City_____ St _____ Zip _____

Your Employer _____

Emergency contact _____ Phone number_____ Relationship_____

Who is financially responsible_____ Address and phone if not same as patient _____

Whom may we thank for referring you to our practice? _____

PRIMARY Dental Insurance Information

Insured name _____ DOB_____ Employer _____

Insurance Co _____ Address _____

Ins. Ph# _____ Insured SS# or ID# _____ Group number _____

Relationship to patient: _____ Self _____ Spouse _____ Other

SECONDARY Dental Insurance Information

Insured name _____ DOB_____ Employer _____

Insurance Co _____ Address _____

Ins. Ph# _____ Insured SS# or ID# _____ Group number_____

Relationship to patient: _____ Self _____ Spouse _____ Other

INSURANCE Authorization:

_____ By initialing this line, I authorize my insurance company to pay the dentist all insurance benefits rendered.

- I authorize the use of this electronic signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for and, agree to pay for all charges whether or not paid by insurance. In the event a balance is sent to a collection agency or, collection attorney, I agree to pay for interest at the rate of 18%, court costs, and reasonable attorney fees.

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough Diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

_____

Print Patient Name

_____ _____

Patient Signature (parent or guardian, if minor) Date

Patient Name_____

Dental History

Name/phone number of previous dentist_____ Date of most recent dental exam _____

Please check any of the following dental concerns that apply to you.

- ☐ Trouble getting numb
- ☐ Reaction to anesthetic, or epinephrine
- ☐ Jaw pain/noise
- ☐ Clenching/grinding your teeth
- ☐ Food getting caught between your teeth
- ☐ Chipped or broken teeth
- ☐ Swollen or bleeding gums
- ☐ Have dental implants
- ☐ History of periodontal treatment
- ☐ Toothache
- ☐ Interested in whitening
- ☐ Wear dentures/partials
  Age of denture_____
- ☐ History of orthodontics
- ☐ Sensitivity to sweet
- ☐ Sensitivity to hot/cold
- ☐ Other_____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician Name/Number _____ Specialist Name/Number_____

Are you allergic to any of the following?

- ☐ Penicillin
- ☐ Erythromycin
- ☐ Sulfa
- ☐ Aspirin
- ☐ Latex
- ☐ Metal
- ☐ Other _____

Do you currently:

- ☐ Smoke
- ☐ Use chewing tobacco
- ☐ Vape
- ☐ Use controlled substances

Women: Are you

- ☐ Pregnant (due date)_____
- ☐ Nursing
- ☐ Taking oral contraceptives

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

- ☐ ADD/ADHD
- ☐ AIDS/HIV Positive
- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints (hip, Knee) Date(s)_____
- ☐ Asthma or Other Respiratory Disease _____
- ☐ Autoimmune Disorder
- ☐ Blood Transfusion
- ☐ Cancer _____
- ☐ Chemo/Radiation
- ☐ Diabetes TYPE 1 TYPE 2
- ☐ Epilepsy or seizures
- ☐ Fainting/dizziness
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Hepatitis A B C
- ☐ High or Low Blood Pressure
- ☐ Heart Attack (date)_____
- ☐ Stroke (date)_____
- ☐ Heart Murmur, Mitral Valve Prolapse, or Other Heart Defect (explain) _____
- ☐ Pacemaker, Art. Valve , Stent date(s)_____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Acid Reflux
- ☐ Osteoporosis
- ☐ Taken Bisphosphonates
- ☐ Psychiatric Care _____
- ☐ Sinus Problems
- ☐ Snoring/Sleep Apnea
- ☐ Tuberculosis
- ☐ Herpes/Venereal Disease
- ☐ Other_____

If any conditions or alerts selected above need further clarification, please describe below:

_____

Please list all medications you are taking (or attach list)

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Patient Signature (parent or guardian, if minor) Date

OMNIDENTAL, PC

HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT

OmniDental, PC. Notice of Privacy Practices has been offered to me. I understand I have the right to review the Notice of Privacy Practice prior to signing this document and, by signing this document, acknowledge only that I have been offered a copy of OmniDental's Notice of Privacy Practices.

The Notice of Privacy Practices for OmniDental is available at the front desk if you would like a copy.

OmniDental reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

_____ _____

Printed Name of Patient/Personal Representative Date

_____ _____

Signature of Patient/Personal Representative Patient's DOB

_____

Description of Personal Representative's Authority

_____

I authorize the following individuals to have access to my personal health information:

Name	Relationship
_____	_____
_____	_____
_____	_____