OMEGA DENTAL

14551 W. Indian School Rd. #200
Goodyear, AZ 85395

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

	Please Circle	
Do you have a specific dental problem? Describe _____	Yes	No
Do you have dental examinations on a routine basis? Last visit _____	Yes	No
Do you think you have active decay or gum disease? _____	Yes	No
Do you brush and floss on a routine basis? Discuss _____	Yes	No
Do your gums ever bleed? Discuss _____	Yes	No
Do you like your smile? Why? _____	Yes	No
Does food catch between your teeth? Any loose teeth? _____	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____	Yes	No
Have your past experiences in a dental office always been positive? _____	Yes	No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____	Yes	No
Name of previous dentist (optional): _____		
Date of last full mouth x-rays (16 small films or panoramic) _____		

Medical History

Are you under a physician's care now? Why? Who? _____	Yes	No
Have you ever been hospitalized or had a major operation? Discuss _____	Yes	No
Have you ever had a serious injury to your head or neck? Discuss _____	Yes	No
Are you taking any medications, pills, or drugs? What? _____	Yes	No
Are you on a special diet or have you taken Fen-Phen? Discuss _____	Yes	No
Are you allergic to any medications or substances? Please check box below _____	Yes	No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____		
WOMEN (please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____	Yes	No

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

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Tuberculosis	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
Heart Murmur*	☐	☐	Anemia	☐	☐	Cancer	☐	☐	Kidney Problems	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Radiation Treatments	☐	☐	Renal Dialysis	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Chemotherapy	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Stomach/Intestinal Disease	☐	☐	Parathyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Ulcers	☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse*	☐	☐	Recent Blood Transfusion	☐	☐	Recent Weight Loss	☐	☐	Rheumatism	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Frequent Diarrhea	☐	☐	Pain in Jaw Joints	☐	☐	Glaucoma	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Diabetes	☐	☐	Cortisone Medicine	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problem	☐	☐	Excessive Thirst	☐	☐	Artificial Joint*	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Shortness of Breath	☐	☐	Hypoglycemia	☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐
Heart Surgery*	☐	☐	Frequent Cough	☐	☐	Liver Disease	☐	☐	AIDS	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A (Infectious)	☐	☐	HIV Positive	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hepatitis B (Serum)	☐	☐	Shunts	☐	☐	Allergies (Pollen/Dust)	☐	☐
Blood Disease	☐	☐	Emphysema	☐	☐	Hepatitis C	☐	☐	Drug Addiction	☐	☐	Hives or Rash	☐	☐

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ Date _____ BP _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____

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We are complimented that you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? _____

Patient Information

Date _____ Patient's Name _____ (Last / First / Middle)
Address _____ (Street / City / State / Zip)
Cell Phone (____) _____ Home Phone (____) _____ Social Security # ____ - ____ - ____
Birthdate ____/____/____ If patient is a minor, give parent's/guardian's name _____
If patient is a full-time student, fill in school name _____
Emergency Contact _____ Phone (____) _____

Responsible Party Information

Name _____ (Last / First / Middle / Marital Status)
Residence _____ (Street / City / State / Zip)
Mailing Address _____ (Street / City / State / Zip)
Home Phone (____) _____ Work Phone (____) _____ Social Security # ____ - ____ - ____
Birthdate ____/____/____ Relationship to patient _____
Employer _____ Occupation _____
Employer's Address _____
Insurance Company _____ Group # _____
Insurance Company Address _____
Phone (____) _____

Secondary Insurance Information

If you have dual coverage, please fill out the following:
Spouse's Name _____ Work Phone (____) _____
Social Security # ____ - ____ - ____ Birthdate ____/____/____ Relationship to patient _____
Employer _____ Occupation _____
Employer's Address _____
Insurance Company _____ Group # _____
Insurance Company Address _____ Phone (____) _____

Payment Responsibility

For our patients without dental insurance ... I understand that all responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

For our patients with dental insurance ... I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately repsonsible for payment of <u>all</u> dental services provided in this office for myself or my dependents. My co-payment is due and payable at the time services are rendered. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office.

If it becomes necessary to enlist a collection agency, the responsible party agrees to pay all costs of collection.

I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

X _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

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1. I hereby authorize and direct the dentist (s) of OMEGA DENTAL and / or dental auxiliaries of his / her choice, to perform the following dental treatment or oral surgery procedure (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 crowns).
   E. Removal (extractions) of one or more teeth.
   F. Treatment of diseased or injured oral tissues (hard and / or soft).
   G. Treatment of malposed (crooked) teeth and /or oral development or growth abnormalities.

2. I understand that there are risk involved in this treatment and hereby acknowledge that these risks will be explained to me. That I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of a local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, physical restraints or voice control depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indention or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risk and complications.

4. I recognize that during the course of the treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional or different procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

5. 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 ulcerations and infections 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 the lack of oxygen to the brain that could cause coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctors to use photographs, radiographs, and other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will be required 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.

8. 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.

9. I further understand that this consent will remain in effect until such time that I chose to terminate it.

Date:_____ **Time:**_____ **AM/PM** **File No.** _____

Patients Name: _____

Name of Parent or Guardian:_____

Relationship to Patient: _____

X _____ _____

Signature - Patient or Parent or Guardian **Witness**