Gilbert Omido, DDS, P.A.

Date:

A copy of our Privacy Practices is available at your request

1 PATIENT INFO

Patient Name _____
LastName

_____
First Name Middle Initial

Address_____

City _____

State_____ Zip _____

Sex __M __F Age _____ Birthdate _____

SS#: _____

__Married __Widowed __Single
__Minor __Seperated __Divorced

Occupation_____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Whom may we thank for referring you?

3 PHONE NUMBERS

Home _____ Cell _____

Best time and Place to reach you: _____

E-mail _____

How would you like to receive appointment confirmations?

(check all that apply)

__ By phone __ By text __ By email

IN CASE OF EMERGENCY CONTACT:

Name _____ Relationship _____

Home _____ Cell _____

2 ACCOUNT INFO

Please have all insurance cards available

Who is responsible for this account? _____

Relationship to patient _____

Is patient covered by insurance? __ Yes __ No

Subscribe Name: _____

Birthdate: _____ ID#: _____

Employer: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with:

_____
(Name of insurance company)

and assign directly to Dr. Omido all insurance benefits. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health practioners.

_____
Signature of Patient or Guardian

Date _____

Relationship to Patient_____

Patient Registration

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WELCOME! Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout your treatment. We encourage you to ask questions and to get involved in treatment decisions. This includes understanding your treatment plan as well as our financial and appointment policies.

Financial Policy:

- **Patients are asked to pay for our services at the time they are rendered.**
- All balances unpaid after **30** days will be assessed a finance charge of 4%.
- We accept cash, check, all major credit cards, and debit cards.
- We offer no interest 3rd party financing with CareCredit.
- We will electronically file insurance claims for all dental insurance companies.
- For insurance companies that we participate with, we will accept assignment of benefits and estimate your copay for you. This means that at each visit we will estimate what we expect your insurance to pay based on past payment and ask that your pay only your estimated copay at the time service is provided. This is only an estimation. I**f there is a balance after the insurance pays, it will be due immediately.**
- For insurance companies that we do not participate with, we do not accept assignment of benefits. What this means is we will ask that you pay for your services in full at the time of the visit, we will file your claim electronically (for a faster response time) and your insurance company will provide benefits directly to you.
- If an insurance company has not paid within 45 days of treatment, full payment will be due from the patient. You may continue to pursue payment from the insurance company on your own.

Missed Appointment Policy:

- **Cancelled Appointment:** If you cancel an appointment one or more days in advance, there are no consequences. Our staff will help you reschedule at a time convenient for you.
- **Late Cancellation/No Show:** If an appointment is cancelled less than one day in advance or missed without contacting at all, there are consequences.
    - **First Miss:** After one No show or Late Cancellation, we will send a letter reminding you of our missed appointment policy. You are not billed for the appointment you missed, but we encourage you to use this as a reminder to speak with our staff if you have questions.
    - **Second Miss:** After the second No Show or Late Cancellation, you will lose the privilege of scheduling your appointments in advance and are placed on Same Day Scheduling. To see the Dr, you will need to call on the day you want an appointment. Our staff will try to work you into our schedule, but if no time is available, you may call and try again another day. When you attend 3 consecutive appointments without a No Show or Late Cancellation, you regain the privilege to schedule in advance.
    - **Third Miss:** After the third No Show or Late Cancellation, you will lose all scheduling privileges. At this time your records will be forwarded to you or the dentist of your choice and no more reservations will be given.
- **Late Arrivals:** Any patient arriving more than fifteen(15) minutes late will be seen only if time allows. It will be at the discretion of the dentist to determine what, if any, treatment will be completed.
- **Office Schedule Changes:** Despite careful scheduling, emergencies can cause delays. We try our very best to stay on time. If you appointment time is affected due to an unforeseen emergency, we'll try to notify you. We know that your time is valuable. You will receive the same quality dental are no matter how our schedule is running.

If you have any questions or concerns regarding our financial or appointment policy, please feel free to discuss them with us at any time.

I, _____, have read and understand the financial policy of this office.

_____ _____

Signature Date

Patient Registration

HEALTH HISTORY FORM

NAME: DOB:

MEDICAL INFORMATION

Are you now under the care of a physician?	Yes	No
Physician Name: Phone:		
Are you in good health?	Yes	No
Has there been any change in your general health within the past year?	Yes	No
If yes, what condition is being treated?		
Date of last physical exam:		
Have you had a serious illness, operation or been hospitalized in the past 5 years?	Yes	No
If yes, what was the illness or problem		
Are you taking or have you recently taken any prescription or OTC medications?	Yes	No
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:		
Do your wear contact lenses?	Yes	No
Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	Yes	No
Date:_____ If yes, any complications? _____		
Are you taking or scheduled to begin taking either of the medication, alendronate (Fosamax)	Yes	No
or risedronate (Actonel) for osteoporosis or Paget's disease?		
Since 2001, were you treated or are you presently scheduled to begin treatement with the intravenous biophosphonates	Yes	No
(Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma		
or metastatic cancer?		
Date Treatment Began: _____		
Do you use controlled substances(drugs)?	Yes	No
Do you use tobacco (smoking, chew, bidis, snuff, e-cigs)?	Yes	No
If so, how interested are you in stopping?		
(circle one) VERY / SOMEWHAT / NOT INTERESTED		
Do you drink alcoholic beverages?	Yes	No
If yes, how much alcohol did you drink in the last 24 hours?		
If yes, how much do you typically drink in a week?		

ALLERGIES - Are you allergic to or have you had a reaction to:

To all **YES** responses specity **TYPE** of reaction

Local anesthetics:	Yes	No	Aspirin:	Yes	No
Penicillin or other antibioitics:	Yes	No	Barbiturates, sedatives, or sleeping pills:	Yes	No
Sulfa drugs:	Yes	No	Codeine or other narcotics:	Yes	No
Metals:	Yes	No	Latex (rubber):	Yes	No
Iodine:	Yes	No	Hay fever/seasonal:	Yes	No
Animals:	Yes	No	Food:	Yes	No
Other:				Yes	No

WOMEN ONLY Are you:

Pregnant? If so, how many weeks:_____	Yes	No
Taking birth control pills or hormonal replacement?	Yes	No
Nursing?	Yes	No

HEALTH HISTORY FORM

Please circle your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve	Yes	No
Previous infective endocarditis	Yes	No
Damaged valves in transplanted heart	Yes	No
Congenital Heart Disease (CHD)		
Unrepaired cyanotic CHD	Yes	No
Repaired (completely) in the last 6 months	Yes	No
Repaired CHD with residual defects	Yes	No
Except for the conditions listed above, antibiotic prophylaxis is no longer recommneded for any other form of CHD		

Cardiovascular	Yes	No	Angina	Yes	No	Arteiosclerosis	Yes	No
Congestive heart failure	Yes	No	Damaged Heart valv	Yes	No	Heart attack	Yes	No
Heart murmur	Yes	No	Low blood pressure	Yes	No	High blood pressure	Yes	No
Other congenital heart defect	Yes	No	Mitral valve prolapse	Yes	No	Pacemaker	Yes	No
Rheumatic Fever	Yes	No	Rheumatic heart dise	Yes	No	Abnormal bleeding	Yes	No
Blood transfusion	Yes	No	Hemophilia	Yes	No	AIDS or HIV infection	Yes	No
Arthritis	Yes	No	Autoimmune diusea	Yes	No	Rheumatoid arthritis	Yes	No
System lupus erthematosus	Yes	No	Asthma	Yes	No	Bronchitis	Yes	No
Emphysema	Yes	No	Sinus trouble	Yes	No	Tuberculosis	Yes	No
Cancer/Chemotherapy/Radiation	Yes	No	Chest pain upon exe	Yes	No	Chronic pain	Yes	No
Diabetes	Yes	No	Eating disorder	Yes	No	Malnutrition	Yes	No
Gastrointestinal disease	Yes	No	G.E. Reflux/persister	Yes	No	Ulcers	Yes	No
Stroke	Yes	No	Thyroid problem	Yes	No	Glaucoma	Yes	No
Hepatitis, Jaundice, Liver disease	Yes	No	Epilepsy	Yes	No	Fainting spells or Seizures	Yes	No
Neurological disorders	Yes	No	Sleep disorder	Yes	No	Mental health disorders	Yes	No
Recurrent infections	Yes	No	Kidney Problems	Yes	No	Night sweats	Yes	No
Osteoporosis	Yes	No	Persistent swollen gl	Yes	No	Severe headaches/migraines	Yes	No
Severe or rapid weight loss	Yes	No	Sexually transmitted	Yes	No	Excessive urination	Yes	No

Has a physicial or previous dentist recommended that you take antibiotics prior to your dental treatment?	Yes	No
Name of physicial or dentist making recommendation?		

Do you have any disease, condition, or problem not listed above that you think I should know about?

Any additional information for items marked YES:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certifiy that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature:

Date: