11010 Prairie Brook Rd Omaha, NE 68144 Ph: 402-571-3415 Fax: 402-571-1057 http://www.ohanasmiles.com

Welcome to Ohana Smiles! Our mission is to provide the most comprehensive dental care for you and your family with a personalized, gentle, and efficient approach.

Please complete the information below:

Personal Information

Today's Date: _____

Name: _____
LAST FIRST MI

I prefer to be called: _____ ☐Male ☐Female

DOB: _____ Age: ___ SSN: _____

Home Address: _____

_____
CITY STATE ZIP CODE

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Occupation: _____

Employer: _____ Years: ____

Work Address: _____

_____
CITY STATE ZIP CODE

Relationship Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name: _____

Children: ☐Yes ☐No How many? _____

Referred by: _____

Account Information

Person responsible: _____

Relationship: _____

DOB:_____ SSN: _____

Phone: _____

Billing Address: _____

_____
CITY STATE ZIP CODE

Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP CODE

Phone: _____

Group #: _____ ID #: _____

Insured's Name: _____

DOB: _____ Relationship: _____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP CODE

Phone: _____

Group #: _____ ID #: _____

Insured's Name: _____

DOB: _____ Relationship: _____

Insured's Employer: _____

Emergency Contact

In the event of an emergency, please contact:

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Physician's Name: _____

Physician's Phone: _____

Dental History

Reason for visit: ☐Exam ☐Emergency ☐Consult

Are you in pain? ☐Yes ☐No How long? _____

Do you require pre-medication? ☐Yes ☐No

Please check any of the following problems:

☐Discomfort, clicking, or popping in jaw
☐Red, swollen, or bleeding gums
☐Sensitive tooth, teeth, or gums
☐Blisters/Sores in or around the mouth
☐Lost/Broken fillings
☐Teeth grinding
☐Ringing in ears
☐Broken/Chipped tooth
☐Stained teeth
☐Locking jaw
☐Bad breath
☐Other: _____

Previous Dentist: _____

Phone: _____

Last Dental Exam: _____ ☐Unsure

Last Dental X-Ray: _____ ☐Unsure

Times a Day You Brush: _____

Times a Week You Floss: _____

What type of toothbrush bristles do you use?

☐Soft ☐Medium ☐Hard

How would you rate your smile?

Worst ☐1 ☐2 ☐3 ☐4 ☐5 Best

Are you interested in teeth whitening? ☐Yes ☐No

Medications

What medications are you taking?

_____

_____

_____

_____

Have you ever taken:
☐Bisphosphonates ☐Phen-fen/Redux ☐Neither

Medical History

Do you or have you had any of the following diseases, medical conditions, or procedures?

☐Heart attack/stroke
☐Heart surg/pacemaker
☐Heart murmur
☐Rheumatic fever
☐Mitral valve prolapse
☐Artificial valves
☐Heart disease
☐Congenital heart defect
☐Chest pains
☐Scarlet fever
☐Nervousness
☐Thyroid problems
☐Liver problems
☐Kidney problems
☐Respiratory problems
☐Sinus problems
☐Stomach problems
☐Psychiatric problems
☐Cancer/Tumors
☐Chemotherapy
☐Shingles
☐Tuberculosis
☐Venereal disease
☐Alcohol/Drug abuse
☐Hepatitis
☐HIV/AIDS
☐Arthritis/Rheumatism
☐Joint Replacement
☐Difficulty breathing
☐Asthma
☐Emphysema
☐Cosmetic surgery
☐X-Ray or cobalt treatment
☐Frequent neck pain
☐Back problems
☐Jaw problems
☐Diabetes/Hypoglycemia
☐High/Low blood pressure
☐Leukemia
☐Anemia
☐Bleeding problems
☐Severe/Frequent headache
☐Fainting/Seizure/Epilepsy
☐Glaucoma
☐Other: _____

Are you allergic to any of the following:
☐Latex ☐Penicillin/Amoxicillin ☐Tetracycline
☐Aspirin ☐Dental anesthetics ☐Foods
☐Other: _____

Do you use tobacco products? ☐Yes ☐No

Method: _____

Quantity: _____ How long? _____

How would you rate your general health?

Worst ☐1 ☐2 ☐3 ☐4 ☐5 Best

☐Contact Lenses ☐Birth Control ☐Nursing

☐Pregnant, how long? _____

☐Children, how many? _____

I authorize Ohana Smiles to perform any necessary services during diagnosis and treatment, I guarantee this form was completed correctly to the best of my knowledge, and I understand it is my responsibility to inform Ohana Smiles of any changes to the information I have provided.

X _____ Date _____

Ohana Smiles Financial Policy

Thank you for choosing Ohana Smiles as your dental healthcare provider. We are committed to providing you with quality dental care. The following is a statement of our financial policy, which we require you read, agree to, and sign prior to any treatment. Please note that full payment is due at the time of treatment and all charges incurred are the patient's responsibility regardless of insurance coverage.

Insurance: We do not accept Medicare or Medicaid. As a courtesy, we will file claims on your behalf with your insurance company immediately after your treatment. Please note that an insurance policy is a contract between your insurance company and you. If you have questions regarding coverage, you must contact the insurance company directly. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates unless our office is a preferred provider.

If you are a new patient, please present your insurance card prior to treatment. If we are unable to verify your insurance, full payment is due at the time of treatment. If your insurance has changed, it is your responsibility to update our office with the new information.

Payments: Our office does not accept partial payments or payment plans. We accept payment in the forms of cash, check, Visa, or MasterCard. At the time of treatment, the estimated amount is due. After we receive payment from your insurance company, the remaining balance is due in full. Any adult accompanying a minor is responsible for the payment due at the time of service as well as providing us with the appropriate insurance information, if applicable. If we do not receive payment from your insurance company within 30 days of submitting the claim, you will be responsible for full payment. If we receive subsequent payment from your insurance company, you will be refunded. Please note that returned checks will be subject to additional fees.

If you do not have insurance, a 10% discount will be given if paying by cash or check at the time of treatment.

Overdue Accounts: You are responsible for late, legal, or collection-related fees. Any balance unpaid within 60 days of treatment is subject to a $25/$50 late fee for accounts with a balance under/over $400. Accounts past due for 90 days will be sent to collection agencies with a 35% collection fee of the balance.

Late Cancellations/Missed Appointments: We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call us at least 48 hours in advance of your appointment time to reschedule or a $50 late cancellation fee will be assessed to your account. If you are more than 15 minutes late for an appointment, you may need to reschedule. If you miss your appointment without cancellation, a missed appointment fee of $50 per hour will be assessed. Your appointment time is only reserved for you and we have to pay our staff even if you are not here. Please help us serve you better by keeping scheduled appointments or changing it in a timely manner. Excessive abuse of scheduled appointments will result in dismissal from our office.

HIPAA Privacy: We thank you for the opportunity to provide you with quality dental care. We respect all of our patients and wish to keep you notified of our policies. Ohana Smiles follows HIPAA privacy laws and has a copy of HIPAA regulations available at your request. If we change our privacy practices or financial policy, we will post a copy in our office in a prominent location, have copies of the revised notice at our office and on our website, and provide you with a copy upon your request.

Understanding, Authorization, and Release: I have read, understood, and agreed to all of the terms listed in Ohana Smiles Financial Policy. I authorize Ohana Smiles to release any information including the diagnosis and the records of any treatment or examination rendered to my dependent(s) or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Ohana Smiles or dental group insurance benefits otherwise payable to me. I agree to be responsible for payment and related charges of all services rendered on my behalf or my dependent(s).

X _____ Date _____

Signature of Patient or Responsible Party

(Print) _____