

WELCOME

*Thank you for trusting us with your dental care.
We promise to do our best to provide you with the finest care available.*

Patient Information

Name _____ Date _____
Address _____ City _____
State _____ Zip Code _____ DOB _____ Employer _____
Home Ph # _____ Cell Ph # _____ Preferred Contact Method _____
Social Security # _____ Email Address _____
Emergency Contact _____ Phone # _____
Whom may we thank for referring you/how did you hear about our office? _____

Responsible Party

Name _____ Phone # _____
Address _____ City _____ State _____ Zip Code _____
Relationship to patient _____

Dental Insurance Information

Subscriber _____ Date of Birth _____
Insurance Company Name _____ ID# or SS# _____
Group # _____ Employer _____

I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Martine all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Dr. Martine may use my health care information and may disclose such information to the above named insurance company for the purpose of obtaining payment for services.

Signature of patient/parent/guardian _____ Date _____

Dental History

Reason for today's visit? _____ Date of last dental visit? _____
Former Dentist? _____ Date of last dental x-rays? _____

Please check all that apply, past or present

_____ Bad breath	_____ Bleeding gums	_____ Blisters on lips/gums
_____ Burning sensation on tongue	_____ Chew on one side	_____ Clicking/popping jaw
_____ Fingernail biting	_____ Food collection	_____ Grinding teeth
_____ Gums swollen/tender	_____ Jaw pain/tiredness	_____ Lip/cheek biting
_____ Loose/broken teeth	_____ Mouth breathing	_____ Mouth pain
_____ Oral piercings	_____ Orthodontic treatment	_____ Periodontal treatment
_____ Recreational drugs	_____ Smoking: cannabis, cigar, cigarette, pipe	_____ Sores/growths
_____ Vaping: cannabis, nicotine		

How often do you brush? _____ How often do you floss? _____

Medical History

Primary Care Physician _____ Phone # _____
Date of Last Visit _____ Are you now under medical treatment? _____
If yes, please explain _____

Please **check any** of the following that you have experienced:

___ Abnormal bleeding	___ Acid reflux	___ AIDS/HIV
___ Anemia	___ Arthritis	___ Artificial heart valve
___ Artificial joints	___ Asthma	___ Back problems
___ Blood disease	___ Cancer	___ Chemotherapy/radiation
___ Circulatory Problems	___ Congenital heart lesions	___ Cough, bloody/persistent
___ PreDiabetes/Diabetes	___ Eating disorder	___ Emphysema
___ Fainting/dizziness	___ Headaches/migraines	___ Heart Problems
___ Hepatitis Type _____	___ Herpes	___ High/low blood pressure
___ Jaundice	___ Kidney disease	___ Liver disease
___ Nervous problems	___ Osteoporosis	___ Psychiatric care
___ Pacemaker	___ Respiratory disease	___ Shortness of breath
___ Sinus trouble	___ Sleep Apnea	___ Stroke
___ Swollen feet/ankles	___ Swollen glands	___ Thyroid problems
___ Tuberculosis	___ Tumor/growth on head/neck	___ Ventricular assisted device

Are you pregnant? ___no ___yes Are you nursing? ___no ___yes
Have you ever taken medication for osteoporosis (past or present)? ___no ___yes

Medications/Supplements

List any medications/supplements you are currently taking and their correlating diagnosis or reason for use. _____

Allergies

Please **check** or **list** any allergies you may have:

___ Amoxicillin	___ Local Anesthetic
___ Aspirin	___ Metals
___ Barbiturates (Sleeping Pills)	___ Penicillin
___ Clindamycin	___ Tetracycline
___ Doxycycline Monohydrate	___ Other _____
___ Erythromycin	_____
___ Keflex	_____

FINANCIAL RESPONSIBILITY AGREEMENT & PAYMENT OPTIONS

FOR OUR PATIENTS WITH DENTAL INSURANCE

We will gladly process your insurance claims with the following agreement:

- Your dental insurance is an agreement between you and your insurance company. Patient should present dental insurance card and be aware of his/her benefits including network participation, frequencies, limitations, and maximum benefit amounts.
- As part of your contract with your insurance company, you are responsible for all out-of-pocket costs/copayments and deductibles.

IF WE ARE NOT BILLING DENTAL INSURANCE

- We offer a 5% discount.
- Payment in full is due at the time of service.

PAYMENT OPTIONS

- For your convenience, we accept Visa, Master Card, Discover, American Express, personal checks or cash.
- Payment arrangements may be made for services rendered over \$500 through automatic draft of credit or debit card with weekly or monthly payments.

CONCERGE MEMBERSHIP

- Martine Dental offers a Concierge Membership to our patients. The membership provides services at a reduced fee. Membership is paid monthly and is billed automatically through a credit or debit card. Details can be provided by our Office Manager.

BILLING

- Any billing statement you receive constitutes an outstanding balance and is due in full within 15 days upon receipt. Accounts outstanding more than 60 days from date of first statement will be charged 2% per month penalty. After 90 days, the account will be sent to collections. If the account is sent to collections, you will be responsible for all collection fees including balance, interest, court costs & attorney fees.

MISSED APPOINTMENT AND CANCELLATION POLICY

- We understand that your plans and daily schedule can change. A minimum of 48 hour notice is greatly appreciated when you need to reschedule your appointment. A fee of \$50 may be assessed if a 48 hour notice is not given.

I have read and understand the above policies.

Signature _____ Date _____

MARTINE DENTAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare options. For example:

Treatment: We may use or disclose your health information to a physician, other healthcare provider, and/or insurance companies providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operation.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing any health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, x-ray or dental records.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post cards or letters).

PATIENT RIGHTS

Access: You have the right to get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information.

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health insurance. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS:

If you are concerned that we may have violated your privacy rights, you may complain to us in writing and/or you may also submit a written complaint to the U.S. Department of Health & Human Services.

MARTINE DENTAL
ACKNOWLEDMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practice.

Signature _____ Date _____

Printed Name _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- _____ Individual refused to sign.
- _____ Communication barriers prohibited obtaining acknowledgment.
- _____ An emergency situation prevented us from obtaining acknowledgment.
- _____ Other (specify) _____

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Date _____

MARTINE DENTISTRY

MINOR CONSENT

I, being the parent/guardian of _____

Print Minor's Name

do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

I agree that I, as the parent or guardian are responsible for all fees and services for all treatment. I accept full responsibility for all charges not covered by insurance.

Signature of Parent/Guardian

Date