ROBERT F. MARTIN, JR., D.M.D. • General and Orthodontic Dentistry • Greenville, AL

PATIENT'S NAME _____ DATE _____

MEDICAL HISTORY

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For What?		
Are you currently taking any medication (including Viagra, Herbal Supplements & Antacids)?	☐	☐
If Yes, What?		
Are you pregnant?	☐	☐
Do you smoke CIGARETTES, PIPE, OR CIGAR? (CIRCLE)	☐	☐

FAMILY PHYSICIAN _____ DATE OF LAST PHYSICAL EXAM _____ PHONE#: _____

ANSWER YES OR NO TO THE FOLLOWING WHICH YOU MAY HAVE OR HAVE HAD.

	YES	NO		YES	NO
Heart Failure	☐	☐	Osteoporosis	☐	☐
Heart Disease or Attack	☐	☐	Fever Blisters	☐	☐
Angina Pectoris	☐	☐	Epilepsy or Seizures	☐	☐
High Blood Pressure	☐	☐	Fainting or Dizzy Spells	☐	☐
Heart Murmur	☐	☐	Nervousness	☐	☐
Rheumatic Fever	☐	☐	Psychiatric Treatment	☐	☐
Congenital Heart Lesions	☐	☐	Sickle Cell Disease	☐	☐
Scarlet Fever	☐	☐	Glaucoma	☐	☐
Artificial Heart Valve	☐	☐	Chemotherapy (Cancer, Leukemia)	☐	☐
Heart Pacemaker	☐	☐	Venereal Disease (Syphilis, Gonorrhea, etc.)	☐	☐
Heart Surgery	☐	☐	Bruise Easily	☐	☐
Artificial Joints (Hip, Knee)	☐	☐	Emphysema	☐	☐
Anemia	☐	☐	Tuberculosis (TB)	☐	☐
Stroke	☐	☐	Asthma	☐	☐
Kidney Trouble	☐	☐	Hay Fever	☐	☐
Ulcers	☐	☐	Sinus Trouble	☐	☐
Cosmetic Surgery	☐	☐	Allergies or Hives	☐	☐
A.I.D.S.	☐	☐	Diabetes	☐	☐
Hepatitis A (infectious)	☐	☐	Thyroid Disease	☐	☐
Hepatitis B (serum)	☐	☐	X-ray or Cobalt Treatment	☐	☐
Liver Disease	☐	☐	Arthritis	☐	☐
Yellow Jaundice	☐	☐	Rheumatism	☐	☐
Blood Transfusion	☐	☐	Cortisone Medicine	☐	☐
Drug Addiction	☐	☐	Pain in Jaw Joints	☐	☐
Hemophilia	☐	☐	Alcoholism	☐	☐
Bleeding Problems	☐	☐			

Are you ALLERGIC or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO
Aspirin	☐	☐	Percodan	☐	☐	Erythromycin	☐	☐
Darvon	☐	☐	Local Anesthetic	☐	☐	Valium	☐	☐
Nitrous Oxide	☐	☐	Codeine	☐	☐	Penicillin	☐	☐
Cortisone	☐	☐	Ativan	☐	☐	Halcion	☐	☐
						Versed	☐	☐

Are you aware of being ALLERGIC to any other medications or substances? (Latex, etc.)
If yes, please list _____

Is there any other Medical or Dental information that you feel I should know about?

_____

_____

_____

CONSENT:
The undersigned hereby authorizes Doctor or staff 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 needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, including the use of nitrous oxide, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk X _____.
I understand the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I understand that I am responsible for all court costs and collection expenses incurred as a result of legal action due to a delinquent account. I also assign all insurance benefits to the Doctor.

PATIENT Signature (Parent of Child) X _____ Date _____

PATIENT INFORMATION AND HEALTH HISTORY

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

SEX _____ MARITAL STATUS _____ PATIENT'S SS# _____

HOME ADDRESS _____ HOME PHONE _____ CELL# _____

CITY _____ STATE _____ ZIP _____

PATIENT EMPLOYED BY _____ BUSINESS PHONE _____

SPOUSE'S NAME _____ SPOUSE'S DATE OF BIRTH _____ SPOUSE'S SS# _____

SPOUSE EMPLOYED BY _____ SPOUSE'S BUSINESS PHONE _____

WHO SENT YOU? _____

PERSON RESPONSIBLE FOR BILL ARE YOU A FULL TIME STUDENT? YES NO

IF PATIENT IS A MINOR WE NEED:

FATHER'S NAME _____ FATHER'S SS# _____

FATHER'S EMPLOYER _____ FATHER'S BUSINESS PHONE _____

MOTHER'S NAME _____ MOTHER'S SS# _____

MOTHER'S EMPLOYER _____ MOTHER'S BUSINESS PHONE _____

EMERGENCY INFORMATION:

Name, Address & Telephone of a Relative Not living with you _____

_____

_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec.# _____ Group# _____ Local# _____

If you have double dental insurance coverage complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec.# _____ Group# _____ Local# _____

IT IS IMPORTANT THAT I KNOW ABOUT YOUR DENTAL AND MEDICAL HISTORY. MANY THINGS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH. INFORMATION YOU GIVE ME IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR WRITTEN PERMISSION.

DENTAL HISTORY

	YES	NO
How LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: *(Machine that rotates around your head, or 16 small films.)*		
Are you having PROBLEMS now?	☐	☐
WHAT?	☐	☐
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Have you had BAD dental experiences in the past?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED	☐	☐

	YES	NO
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Do you have LOOSE, TIPPED, or SHIFTING teeth? (circle)	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you have problems with teeth/fillings BREAKING?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	☐	☐
Name of Previous Dentist:		
City: State:		
How do you feel about your teeth?		

Robert F. Martin, Jr., D.M.D.

137 Interstate Drive

Greenville, AL 36037

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ Patient's Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Lisa Price** Address: **137 Interstate Drive, Greenville, AL 36037**

Telephone: **334-382-9610** Fax: **334-382-2930** E-mail: **smilsrus@alaweb.com**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Name of Patient:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

Signature (patient or legal guardian): _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

APPOINTMENT POLICY

We know your time is valuable and we respect that. In return, we ask that you do the same in reference to our time. Your appointment(s) are scheduled for times that are most convenient for you and your appointment time is reserved ***just for you.***

Our office strives to maintain a timely schedule, however, on occasion emergencies do arise beyond our control and we may be unable to stay on schedule. Be assured that if you were to have an emergency you will be treated with the same concern and consideration.

Dr. Martin requires at least 48 hours notice to change a scheduled appointment or you could be subject to a non-refundable deposit to be paid to reserve any appointment(s) in the future.

We trust that you will respect our time and arrive at our office on time for ***your reserved*** appointment time.

Thank you.

I have read, understand and agree with the above written appointment policy.

_____**date**_____

(Patient or guardian)

- **DENTAL INSURANCE**

Most insurance companies will not cover 100% of all dental expenses. Your portion, not covered by insurance, is due at the time treatment is performed.

Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist. The patient is still the responsible party regarding dental fees. We will be glad to process your insurance forms at no charge.

Please be aware that we are only capable of approximating your portion due to the large number of insurance companies and to their periodic changes within their contracts without notifying each dental office of these changes.

- **CASH, CHECK OR CREDIT CARD**

Payment in full is due when services are performed.

- **DENTAL FINANCE PLAN**

We've made arrangements with a finance company that will finance your dental work with approved credit. This will allow you to complete your dental work without delay and make relatively small monthly payments. Brochures are available at the reception desk.

- **GRADUAL TREATMENT PLAN**

If it will be easier financially for those patients without dental insurance, we can plan the completion of your dental work by spreading your appointments over several months or years. We will arrange to do the more urgent services at the beginning of treatment.

DESIGNATED FINANCIAL OPTIONS

- **DENTAL INSURANCE**
- **CASH, CHECK OR CREDIT CARD**
- **DENTAL FINANCE PLAN**
- **GRADUAL TREATMENT PLAN**

_____ _____

Credit card number Exp Date

ADDITIONAL FINANCIAL ARRANGEMENTS:

I understand **Dr. Robert F. Martin's** financial policies and agree to the above arrangements.

Signed:_____

DR. ROBERT F. MARTIN, JR. AND YOUR INSURANCE PLAN—HOW THEY WORK TOGETHER

The staff at Dr. Robert F. Martin, JR's office are pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept all private insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means we work with literally thousands of companies. Although we maintain computerized histories of payment by a given company, they do change, therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is, **ONLY AN ESTIMATE**, if you would like to know your exact insurance benefit we will be happy to file a "pretreatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figure you may require.

I THOUGHT I PAID MY PORTION, BUT I GOT A BILL. WHY????

We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining Dr. Robert F. Martin, JR's dental family, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan, so we can adjust accordingly.

INSURANCE DIDN'T PAY, NOW WHAT??????

We bill your insurance as a courtesy. If insurance does not pay within 60 days, Dr. Robert F. Martin, JR's dental office reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize the insurance you have as a legal contract between **YOU** and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all the charges incurred in our office.

FINANCIAL OPTIONS

Dr. Robert F. Martin, JR's office does request payment in full for your portion at the time of service. We accept MasterCard, VISA, and Discover. If you are in need of an extended finance option, we also work with Dental Fee Plan, who offers up to 48 months to pay. Just ask a member of the Patient Service staff about this plan.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Dr. Robert F. Martin, JR's Office

*Signature*_____ *Date*_____