CHARLES MARTIN, DDS
COSMETIC AND GENERAL DENTISTRY

Welcome to Our Office
1810 S. MacDill Ave., #3 - Tampa, FL 33629

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

PATIENT INFORMATION: **Date** _____

Name _____ **Cell Phone** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Sex _____ **Age** _____ **Date of Birth** _____ **Marital Status** _____

Social Security # _____ **Email Address** _____

Employed by _____ **Occupation** _____

Business Address _____**Phone** _____

Contact Information in case of emergency _____

How did you hear about us? Whom should we thank for referring you? _____

DENTAL HISTORY:

Reason for today's visit? _____

Date of last cleaning, x-rays and exam? _____

Particular area of concern you would like us to pay special attention to today? _____

_____

Are you happy with:

The color of your teeth? **Yes / No**
The shape of your teeth? **Yes / No**
The size of your teeth? **Yes / No**

Other? _____

What do you like about your smile?
_____

Please place a check in the box next to any problems you have had with the following:

- ☐ **Bad Breath**
- ☐ **Bleeding gums**
- ☐ **Clicking or popping jaw**
- ☐ **Jaw pain**
- ☐ **Food collection between teeth**
- ☐ **Loose or broken fillings**
- ☐ **Periodontal treatment**
- ☐ **Teeth Grinding**
- ☐ **Sensitivity to hot or cold**
- ☐ **Sensitivity to sweets**
- ☐ **Pressure when biting**
- ☐ **Sores/growths in or outside of the mouth**

MEDICAL HISTORY:

Primary care physician's name _____Date of last visit_____

List any serious illness or operation that you may have had. If yes, describe

_____

(Women) Are you pregnant? _____Nursing _____

Do you premedicate prior to your dental visit? If so, please list medication

_____

PLEASE CHECK BOXES IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

- ☐ AIDS
- ☐ Anemia
- ☐ Rheumatoid Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Persistent Cough
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Migraine Headaches
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of feet/ankles
- ☐ Thyroid
- ☐ Tobacco Habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ HPV

Pharmacy Name/Number _____

Medications currently taking: _____

ALLERGIES: Check all that apply:

- ☐ ASPIRIN
- ☐ SLEEPING PILLS
- ☐ BARBITURATES
- ☐ LOCAL ANESTHETICS
- ☐ PENICILLIN
- ☐ CODEINE
- ☐ CLINDAMYCIN
- ☐ LATEX
- ☐ Other:_____
  _____
  _____

Do you smoke?_____ If yes, how often?_____

Do you use chewing tobacco?_____ If yes, how often?_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date _____ Signature _____

DENTAL INSURANCE INFORMATION: Our office is "fee for service", which means we collect all fees at the time of service. However, if you do have dental insurance we want to help you receive your benefits. We can do that by collecting your insurance information, filing your claim electronically, and having the payment of your benefit sent directly to you. This is typically a fast process—you should hear from your insurance company within 2-3 weeks, although ***we cannot guarantee what the reimbursement amount will be.*** We suggest you file a *pre-treatment estimate* request for all major work if you desire to know your benefit amount in advance. Please provide complete insurance information if you would like us to file claims for you.

Insurance Company: _____

Address: _____

Phone Number: _____

Group Number: _____

I.D. # or S.S. #: _____

Subscriber name: _____

Relationship to patient: _____

Subscriber Date of Birth: _____

S.S. #: _____

Subscriber employed by: _____

AUTHORIZATION:

I authorize my insurance company to **pay me** directly for all insurance benefits otherwise payable to the dentist for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all services performed at time of treatment.

SIGNATURE: _____

DATE: _____

THANK YOU!

HIPAA PATIENT CONSENT FORM

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)**
- **Obtaining payment from third party payers (e.g. my insurance company)**
- **The day-to-day healthcare operations of our practice**

I have also been informed I may review this office's copy of Notice of Privacy Practices, which contains a more complete description of uses and disclosures of my protected health information, and my rights under HIPAA. I understand this office reserves the right to change the terms of this notice from time to time and I may view the most current copy of the terms.

I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care. (See next form)

I understand I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20___.

Print Patient Name _____

Relationship to Patient: (self or guardian) _____

Signature _____

HIPAA PATIENT AUTHORIZATION FORM

This authorization sets forth your right to use or disclose my protected health information as specified below for the purposes and parties as designated below.

Description of specific information authorized: (list if you have specific direction)

Description of the specific purposes for use and disclosure:

Names of Relatives, Close Friends, or Caregivers to whom your health information may be disclosed _____

I reserve the right to:

- **Revoke this authorization in writing by submitting it to the attention of our office**
- **Inspect or copy the protected health information to be used or disclosed**
- **Refuse to sign this authorization knowing the office will not condition treatment or payment on my providing this authorization.**

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

This authorization is effective from ____ day of _____. 20____

Print Patient Name _____

Relationship (if other than patient) _____

Signature _____