Patient Registration

MartinDental
General, Cosmetic, and Implant Dentistry
Tony P. Martin, D.D.S. S.C.
1608 Ohm Avenue · Eau Claire, WI 54701
(715) 835-8311 · www.martindentalec.com

Patient Information

☐ I am the Responsible Party ☐ I am the Primary Insurance Policy Holder ☐ I am the Secondary Insurance Policy Holder

First Name: _____ Last Name: _____ Middle Initial: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext.: _____

☐ I would like to receive reminders & information via text message.

Email Address: _____

☐ I would like to receive reminders & information via email.

Social Security Number: _____ Driver's License: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

Student Status: ☐ Full-Time ☐ Part-Time

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Referred by: _____

Previous Dentist: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext.: _____

Social Security Number: _____ Driver's License: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Subscriber: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Social Security Number of Subscriber: _____ Date of Birth of Subscriber: _____

Subscriber's Employer: _____ Insurance Company: _____

Secondary Insurance Information

Name of Subscriber: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Social Security Number of Subscriber: _____ Date of Birth of Subscriber: _____

Subscriber's Employer: _____ Insurance Company: _____

Medical History

Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an influence on the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Women, are you: Pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pace Maker ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No	

Have you ever had any serious condition not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that Tony P. Martin, D.D.S., S.C.'s Notice of Privacy for protected health information has been made available to me as required under both Federal and Wisconsin Law.

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practice Notice: 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 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 is available from our office at any time it is requested.

Uses and Disclosures Being Authorized

Our Use of Medical Information: By signing this form, you will consent to our use of your patient health care records, mental health treatment records, and HIV test information to carry out treatment, payment activities, and health care operations as set forth in our Notice of Privacy Practices.

Other persons (Friend, Parent, Son, Daughter, etc.) Involved in Care: By checking the box below you indicate your consent to:

- ☐ Our disclosure of your health care records, mental health treatment records, and HIV test results for disaster relief purposes as permitted by law, and to the following named persons, including those involved in your care or payment for that care:

  _____
  _____
  _____

_____
Print Name of Patient

_____ Date _____
Signature of Patient/Personal Representative

_____
Print Name of Parent/Personal Representative, if other than patient

Tony P. Martin D.D.S., S.C.

Thank you for choosing Martin Dental for your dental care needs. We appreciate your trust in us and the opportunity to serve you. In an effort to contain costs, we require that all patients read and consent to this Financial Policy prior to treatment. If you have any questions, we will be happy to discuss our policy with you.

FINANCIAL POLICY

PAYMENT: All fees for routine dental services (examination and x-rays) are due in full on the date service is rendered unless pre-arrangements have been made with the Doctor. We accept ***cash***, ***checks***, ***credit cards*** (VISA, MasterCard, Discover and American Express), ***Care Credit***, and nearly all forms of ***insurance***. The patient assumes co-pays, deductibles, and remaining Patient Responsibility.

DISCOUNT: For patients without dental insurance, we offer a five percent (5%) courtesy discount when paying by cash or check and two and a half percent (2.5%) by credit card for payments made in full at the time of service.

MAJOR PROCDEDURES: For patients without dental insurance, all major work, such as crown and bridge, dentures, partial dentures, root canal therapy, root planing, or extensive general dentistry ***will require a down payment*** equal to one-half of the total cost for the first visit in which treatment is started. The remaining balance is due upon the completion of treatment unless other payment arrangements have been made with the Doctor.

INSURANCE: We submit claims to most insurance carriers. Please remember that insurance coverage is a contract between you and your carrier. You, the insured, are responsible for payment on claims that are 1) denied, 2) unpaid due to deductible, 3) partially paid, or 4) specifically partially paid due to the carrier's arbitrary determination of "usual and customary" rates. All balances are due and payable upon receipt.

> **In-Network Non-Covered Charges:** If you have an in-network insurance plan, there may be some services that are considered non-covered based on the insurance company. These non-covered services are Patient Responsibility and will be an out-of-pocket expense.

CARE CREDIT: We are a Care Credit Participating Provider. For your convenience and affordability, the Care Credit Program offers a choice of payment plan options to fit your needs. This financing program is an agreement between you and Care Credit. We require a minimum balance of $300.00 to utilize the Care Credit financing plan.

MINOR PATIENTS: Parents must accompany minor patients to their first dental appointment. For unaccompanied minors, nonemergency treatment may be denied without proper insurance documentation or payment arrangements.

DELINQUENT ACCOUNTS: Delinquent balances will be forwarded to the collection agency after all reasonable attempts to collect have failed. To remain an active patient, it will be expected that you pay the collection fee incurred and may be required to prepay future appointments to bring your account history in good standing.

CANCELLED OR FAILED APPOINTMENTS: We understand that from time to time emergencies arise which may require that you miss a prescheduled appointment. However, as our time is valuable, we politely request a 24 hour notification to make changes to an appointment. This allows our office time to attempt to fill the vacancy. A history of last-minute cancellations or failed appointments may result in a down payment to hold your next appointment.

I have read this Financial Policy, understand its contents, and agree to abide by the policy for all services provided by Martin Dental.

_____	_____	_____
Print Name	*Signature*	*Date*

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Record Release Form

I, _____ hereby authorize
(Patient Name)

_____
(Party with records) to provide copies of my dental records with

respect to any dental treatment to_____.
(Party where records are needed)

I understand that the specific type of information to be disclosed includes a detailed report of examinations, findings, treatments, prognosis and copies of any and all other records, including x-rays, which pertain to me. I agree to pay reasonable duplicating costs for any x-rays requested.

This consent is voluntary. We will not condition your treatment on receiving this consent. Not everyone is subject to federal rules protecting patient privacy, and it is possible that your information may be disclosed to someone who is not subject to these rules, so that your information may no longer be protected by federal rules protecting your privacy. For example, we may need to disclose your dental information to another health care provider who is not subject to federal privacy rules because they do not bill electronically, or a health plan that we disclose your information to so they can pay your bill may redisclose your information to an accreditation or regulatory agency that is not subject to federal privacy rules.

This consent is effective for one year from the date signed unless I cancel this consent in writing delivered to the dentist's office listed above. Cancellation of this consent will *not* affect any action taken in reliance on this consent before we received your written notice of cancellation.

Signed: _____
(Patient)

Signed: _____
(Parent, legal guardian, or custodian of the patient if the patient is less than 18 years old)

Address: _____
(Street)

_____
(City) (State) (Zip Code)

Date: _____