WELCOME

Patient Information

Date____________ SS#___________________________

Patient
Last Name______________________________________

First Name_____________________________________

Address____

City____

State_______________ Zip Code___________________

Home Phone#____________ Work #__________________

Cell #____________ E-mail_______________________

Birthdate___________ Marital Status_______________

Patient Employer/School_________________________

Patient Employer Phone_________________________

Spouse's Name___________________________________

Birthdate_____________ SS#______________________

Spouse's Employer________________________________

IN CASE OF EMERGENCY CONTACT (Someone who does not live in your household.)

Name_________________ Phone #__________________

Whom may we thank for referring you or how did you hear about our office?

____

Dental Insurance

Who is responsible for this account?_______________

Relationship to patient___________________________

Dental Insurance Co._____________________________

Group #____

Subscriber's Name________________________________

Birthdate______________ SS#_____________________

Subscriber ID#___________________________________

Employer____

ASSIGNMENT AND RELEASE

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 understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of Patient, Parent or Guardian

Dental History

Reason for today's visit________________
____
Former Dentist__________________________
City/State______________________________
Date of last dental exam_______________
Date of last dental x-rays______________

Please **CHECK** any of the following that apply to your dental health.

__Bad breath
__Bleeding gums
__Blisters on lips or gums
__Burning sensation on tongue
__Chew on one side of the mouth
__Cigarette, pipe or cigar smoking
__ Smokeless tobacco
__Clicking or popping jaw
__Fingernail biting
__Food collection between teeth
__Foreign objects
__Grinding teeth
__Gums swollen or tender
__Jaw pain or tiredness
__Lip or check biting
__Loose or broken teeth
__Mouth breathing
__Mouth pain, brushing
__Orthodontic treatment
__Pain around ear
__Periodontal treatment
__Sensitivity to hot/cold
__Sensitivity to sweets
__Sensitivity when biting
__Sores or growths in mouth

How often do you brush? ____________

How often do floss? ____________

Medical History

Physician________________________Phone #______________Date of last visit__________

Are you now under medical treatment?__yes __no If yes, please explain____________________

____

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

__AIDS/HIV
__Anemia
__Arthritis
__Artificial Heart Valve
__Artificial Joints
__Asthma
__Back Problems
__Bleeding, abnormally, with extractions or surgery
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy
__Circulatory problems
__Congenital Heart Lesions
__Cortisone Treatments
__Cough, Bloody or Persistent
__Diabetes/Family History
__Emphysema
__Epilepsy
__Fainting or Dizziness
__Glaucoma
__Headaches
__Heart Murmur
__Heart Problems
__Hepatitis Type______
__Herpes
__High Blood Pressure
__Jaundice
__Jaw Pain
__Kidney Disease
__Liver Disease
__Low Blood Pressure
__Mitral Valve Prolapse
__Nervous Problems
__Pacemaker
__Psychiatric Care
__Radiation Treatment
__Respiratory Disease
__Rheumatic Fever
__Scarlet Fever
__Shortness of Breath
__Sinus Trouble
__Skin Rash
__Special Diet
__Stroke
__Swollen Feet/Ankles
__Swollen Neck Glands
__Thyroid Problems
__Tonsillitis
__Tuberculosis
__Tumor or growth on head or neck
__Ulcer
__Unexplained Weight Loss
__Venereal Disease

Have you ever taken Fen-Phen/Redux? ___yes ___no
Do you wear contact lenses? ___yes ___no

Women:
Are you pregnant? ___yes ___no Due Date?________________Are you nursing? ___yes ___no
Taking birth control pills? ___yes ___no

Medications/Supplements

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

____
____
____
____
____
____

Allergies

Please **CHECK** or **LIST** any allergies that you may have.

____Amoxicillin
____Aspirin
____Barbiturates (Sleeping pills)
____Codeine
____Iodine
____Latex
____Local Anesthetic
____Metals
____Penicillin
____Sulfa
Other________________
____

PAYMENT OPTIONS

In an effort to keep dental cost reasonable and minimize our billing expenses, while maintaining a high level of professional care, we have established the following payment options for the convenience of our patients.

Dental Insurance
Dental insurance is designed to help pay for part of the cost of dental treatment. Your employer has made this coverage available and we will do our best to maximize its benefits. Dental insurance is not designed to pay for the total cost of dental treatment, but rather to be a partial aid. We will be happy to process your insurance forms. *If your insurance does not pay 100% of the services, we ask that you respect our insurance policy and pay the estimated portion of your treatment at the time services are rendered. If this portion is not paid at the time of services, there will be a $25 "late" fee charged to your account. If you do not have insurance you must pay in full at the time services are rendered or you will be charged this fee.* To avoid billing confusion, we can ask the insurance company to pay its portion directly to our office. Otherwise, if the insurance company pays its portion directly to the patient, we require that you submit the amount to our office upon receipt of the payment.

VISA/MasterCard
Utilizing this method allows you to pay for your treatment on your own schedule.

Care Credit Program
Care Credit is a type of dental credit card. It offers no interest per month for up to one year based on qualification and certain programs. Your monthly payment is as low as $20 or 3% of the balance. The interest our office charges per year is 24%; therefore, we encourage you to apply for the program to save you money. The application process is simple. There is no fee to apply, and qualification notice can be given in minutes. For more information or to fill out an application, please ask our receptionist.

Financial Agreement
This option will be based on credit history. Payment arrangements can be made at a 2% finance charge per month, 24% annually. Please ask our office manager for more information regarding this option.

BILLING

Any *billing statement* constitutes an outstanding account and is payable in full in **10** days upon receipt. Account balances not paid by the due date will be subject to a $5 late fee. Accounts outstanding for more than 60 days from the date of treatment will be charged 3%. then 2% per month. If an account has gone unattended, it will be sent to collections. The patient acknowledges responsibility for court costs, attorney fees, and charges by the collection agency.

APPOINTMENTS

A fee will be charged to your account for failed or cancelled appointments without prior notification of 48 hours. This fee covers only a portion of the overhead. Once an appointment has been made, please remember this time has been *reserved for you.* This charge will be based on the time set aside for you.

FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of treatment for patient(s) and including all members of his/her immediate family, the patient accepts full responsibility. Insurance forms will be completed as a convenience to the patient; however, payment to the doctor is expected at the time services are rendered. The patient agrees that if this account is turned over to a collection agency, he/she will be responsible for all collection fees up to 50% of the principle balance, interest of 21% A.P.R., court costs and reasonable attorney fees. The patient also agrees and assigns any and all insurance benefits to be paid directly to MARTINE DENTAL.

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 IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law 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 operations. 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 operations.

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 you 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 only health information that is directly relevant to the person's involvement in you healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, x-rays, 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, postcards, 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 Communication: 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 information. (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 want more information about our privacy practices, or if you have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department Health and Human Services upon request.

MARTINE DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

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

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only

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

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

____

____

____

Martine Dental
3410 W. 56th Street
Indianapolis, IN 46228

MINOR/CHILD CONSENT

I, being the parent or guardian of

____

Name of Minor/ Child

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 acknowledge that payment is due at the time of treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

____________________ ____

Date **Signature of Parent/Guardian**

Responsible Party Information:

Name:____________________________ **SS#:**________________________

Address:__________________________ **Date of Birth:**_______________

____________________________ **Employer:**___________________

Telephone #:_______________________ **Emp. Phone:**_________________