



WELCOME

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 questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

About You

Name _____
(First) (MI) (Last)

Mr. Mrs. Ms. Dr. I prefer to be called: _____

Birthdate: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Single: Married: Divorced: Widowed: Separated: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Employer: _____ Occupation: _____

What is your preferred method of contact? _____

Who may we thank for referring you?

Other family members seen by us: _____

Responsible Party's Information

His/Her Name: _____
(First) (MI) (Last)

Birthdate: _____ SS#: _____

Employer: _____ Occupation: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Emergency Contact

In the event of an emergency, who would you like us to contact?

Name: _____

Relationship: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Dental Insurance

Primary Dental Insurance

Name of Insurance Co: _____

Address: _____

Phone #: _____

Group #: _____

Insured's Name: _____

Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Name of Insurance Co: _____

Address: _____

Phone #: _____

Group #: _____

Insured's Name: _____

Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

Patient Name: _____ DOB: _____ / _____ / _____

Are you currently under the care of a physician? If YES, Name: _____

Physician's Name: _____ Physician's Phone #: _____

Describe your current physical health: Excellent Fair Poor

Do you Smoke, use Smokeless Tobacco or vape? Yes No Specify: _____

FOR WOMEN: Are you taking birth control pills? Yes No

Are you pregnant? Yes No If yes, # of weeks _____ Are you nursing? Yes No

Yes No Have you ever taken Boniva or Alendronate (Fosamax)? _____

Are you currently taking any prescriptions over the counter drugs herbal supplements appetite suppressants

Do you now or have you ever had any of the following medical conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease / Defect | <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis / Osteopenia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach / Intestinal Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Irregular Heart Beat | <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies (Seasonal) | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Angina / Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No Pain in the Jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions / Seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No Breathing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes - type: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis (TB) | <input type="checkbox"/> Yes <input type="checkbox"/> No Hypoglycemia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma - type: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis - type: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting / Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis - type: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Drug Use / Addiction |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol Addiction |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Cold Sores / Fever Blisters |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joint: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Nervousness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS / HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No Depression |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Autoimmune Disease: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ |

Are you allergic to any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No Erythromycin | <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No Jewelry / Metals | <input type="checkbox"/> Yes <input type="checkbox"/> No Tetracycline |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ |

Yes No Have you ever been hospitalized or had any major operations? _____

Please list any over-the-counter or prescription drugs that you are currently taking.

Medication	Dosage	Reason for Taking Medication

Patient Signature: _____ Date: _____

Why have you come to the dentist today? _____

Are you currently in pain or discomfort with your teeth and/or gums? Yes No

How would you describe the condition of your teeth and gums? Excellent Fair Poor

Previous Dentist: _____

Last Visit Date: _____

Have you had orthodontics? Yes No If YES, at what age? _____

Do you have headaches? Yes No If YES, how often? _____

Questionnaire

Yes No Do you understand the correlation between dental plaque control and the prevention of gum disease?

Yes No Do your gums ever bleed?

Yes No Have you ever been told you have gum disease?

Yes No Do you often feel your breath is not as fresh as it could be?

Yes No Do you grind or clench your teeth?

Yes No Have you ever had pain/discomfort in your jaw joint?

Yes No Do you snore or have you been told you do?

Yes No Do you sleep well? How long? _____

Yes No Would you like to have whiter teeth?

Yes No Would you like your teeth to be straighter?

Yes No Are you unhappy with any silver or discolored fillings?

Yes No Do you have crowns or bridges which are unattractive or unnatural looking?

Yes No Do you sometimes feel uncomfortable with the appearance of your smile?

Yes No Are your teeth crooked or crowded?

Yes No Do you think a more attractive smile would improve your personal and/or professional relationships?

Yes No Are you afraid or anxious to visit the dentist?

Yes No Do you wish that you could feel relaxed at your next dental appointment?

What level of dental care do you think your dental insurance company will cover? Excellent Fair Poor

What level of dental care would you like to have for yourself? Excellent Fair Poor

The information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I authorize any photographs or slides to be taken of me during treatment at Creative Smiles for educational purposes, laboratory fabrication, or internal office use. I fully understand that other dentists, team members, and other patients may view these photos for educational and / or treatment purposes.

Signature: _____

Date: _____



Brett Martin, D.D.S.

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Queen Creek, AZ 85142

Phone: 480-867-4578

Fax: 555-555-5555

HIPAA CONSENT FORM

Patient Name (please print): _____ Date: _____

Patient DOB: _____

HIPAA- Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the notice Privacy Practice is to explain how Brett Martin, D.D.S. may use or disclose your healthcare information. The notice also explains the rights that you are guaranteed under HIPAA regulations. Brett Martin, D.D.S. is required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the notice. Signing below indicates that you have received the Notice of Privacy Practices. I hereby acknowledge that I have received or requested to receive a copy of Brett Martin, D.D.S. Notice of Privacy Practices.

Patient Signature (or Guardian)

Permission to Share Medical/Dental Information:

(including a spouse; optional- you may leave this BOTTOM portion blank)

My medical/dental information may be obtained and/or exchanged written or verbally to:

(Printed Name and Relationship)

Patient Signature (or Guardian)

Date



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

If the patient is less than 18 years of age, a parent or legal guardian must sign.

I, _____ have received a copy of this office's Notice of Privacy Practices
(Please Print Patient's Name)

(Signature of Patient or Parent/Legal Guardian)

(Date)

For Patients who need pre-medication only:

I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whomever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office will mail to me.

(Signature of Patient or Parent/Legal Guardian)

For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Patient reviewed Privacy Practices, but elected not to take a copy home
- Other (Please Specify)

Employee Signature: _____ Date _____



OUR FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dual insurance, we are always available to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. Minors MUST be accompanied by an adult for all treatment.

We accept CASH, CHECKS, VISA, AMERICAN EXPRESS, and MASTERCARD. Financing is also available upon request, prior to treatment.

In most instances, we accept assignment of insurance benefits, in which case your portion of each service is due at the time services are rendered. Those who have dual coverage should discuss their payment plans with the receptionist. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

We will gladly discuss your proposed treatment and answer any questions regarding your insurance.

YOU MUST REALIZE, HOWEVER, THAT:

1. YOUR insurance is a contract between you, your employer, and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) or where "UCR" is defined as Usual, Customary and Reasonable fees for this region; thus, most insurance companies consider our fees Usual, Customary, and Reasonable. However, this statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard cost-of-care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Should your insurance take longer than 60 days to pay, we ask that you take care of the balance due and then be reimbursed, if and when we receive the insurance payment.

Returned checks are subject to an additional \$35 fee.

Missed Appointments.

Because office time and materials are reserved for you, a fee may be assessed for a missed appointment not canceled at least 48 hours in advance. The first such fee will be \$40.00; subsequent fees will be charged at our current hygiene rate. Please help us serve our patients efficiently by keeping your scheduled appointments or giving us as much advance notice as possible of a conflict in your schedule.

We must emphasize that, as dental care providers, our relation is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the day the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

(Responsible Party Signature)

Name of Patient

Name of Responsible Party (if different from patient)

Date

Printed Name of Responsible Party