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| **NEW PATIENT INFORMATION**  Patient’s Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male/Female  Last First  Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Phone # (Home/Mobile): (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary # (Home/Mobile/Work): (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Place of Employment (or school, if a student): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous Dentist (Name/City): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Est. Date of Last Visit: \_\_\_\_\_\_\_\_\_  How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other family members seen by us? \_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| SPOUSE/PARENT/GUARDIAN *(if applicable)*  Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_  Primary Phone (Home or Mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address, *if not the same as above*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **DENTAL INSURANCE (PRIMARY)**  Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Subscriber’s SSN: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_  Subscriber’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Co. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DENTAL INSURANCE (SECONDARY)**  Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Subscriber’s SSN: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_  Subscriber’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Co. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PAYMENTS *\*Payment is due upon time of service, unless otherwise stated & agreed to by both parties\****

***Methods*:**When paying for charges, we accept cash, personal checks, and credit cards.

***Service Charges*:** If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charges will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18%, applied to the last month’s balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

**Person Financially Responsible** (Please Print Name)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION**

I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers, insurance companies, and/or other health professionals.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_ Adult Patient \_\_\_\_ Parent \_\_\_\_ Guardian

**HEALTH HISTORY**

**How would you rate your overall health?** Good Fair Poor

*If fair or poor, please explain:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Physician’s (Medical Doctor’s) Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Name and/or Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy Name & Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Please list any prescription, over-the-counter medicines, and/or herbal/dietary supplements being taken & why:** | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\*\*Are you required to take an antibiotic prior to dental procedures?** \_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had or are you currently experiencing any of the following diseases or medical conditions?**

|  |  |  |
| --- | --- | --- |
| Abnormal Bleeding  Acid Reflux/Heartburn/GERD  AIDS  Angina (chest pain)  Anxiety/Depression  Anemia  Arthritis, Rheumatism  Artificial Heart Valve  Artificial Joints/Implants  *Date \_\_\_\_\_\_\_\_\_\_ Type \_\_\_\_\_\_\_\_\_\_*  *Date \_\_\_\_\_\_\_\_\_\_ Type \_\_\_\_\_\_\_\_\_\_*  Asthma  Back Problems  Bisphosphonates (Boniva, etc.)  Blood Disease  Blood Thinners (Coumadin, Plavix, etc.)  Bleeding Disorder  Cancer  Chemical/Alcohol Dependency  Circulatory Problems  Dementia/Alzheimer’s  Diabetes  *Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | Emphysema/COPD  Endocarditis  Epilepsy  Fainting/Dizziness Glaucoma  Headaches  Hearing Impairment  Heart murmur  Hepatitis  *Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Herpes Simplex Virus  High Blood Pressure  HIV Positive  Jaundice  Kidney Disease  Kidney Dialysis  Liver Disease  Low Blood Pressure  Lupus  Organ Transplant  Osteoporosis  Pacemaker  Psychiatric Care  Radiation Treatment | Rheumatic Fever  Scarlet Fever  Seasonal Allergies/Hay Fever  Shortness of Breath  Sinus Issues  Skin Rash  Sleep Apnea  Stroke  Suppressed Immune System  Thyroid Problems/Disease  Tuberculosis  **Tobacco Use**  Cigarettes  Cigars  Dip/Chew  E-Cigarettes  Vaping  Interested in quitting? Yes No  **Women Only**  Are you pregnant? Yes No  *Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_*  Are you nursing? Yes No |

**Please list hospitalizations *within the last year* (surgeries, emergency room visits, etc.):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you require any special accommodations?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic to any of the following? If so, indicate what kind of reaction you had:**

|  |  |
| --- | --- |
| Foods\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Latex \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Barbiturates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sulfa \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Metals or Dental Materials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Local Anesthetics \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Aspirin or Ibuprofen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Penicillin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Codeine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DENTAL HISTORY**

**Please indicate if you experience any of the following and wish to discuss treatment:**

|  |  |
| --- | --- |
| Bad Breath  Bleeding Gums  Blisters on Lips/Mouth  Burning Sensation on Tongue  Chew on One Side of the Mouth  Clicking or Popping Jaw  Cold Sores  Discolored Teeth  Dry Mouth  Fingernail Biting  Food Collecting Between Teeth  Grinding/Clenching Teeth  Jaw Pain or Tiredness | Lip/Cheek Biting  Loose/Broken Teeth  Mouth Breathing/Snoring  Mouth Pain when Brushing  Orthodontics (Braces, Invisalign/Smile Shapers))  Pain Around Ear  Periodontal treatment  Sensitivity to Cold  Sensitivity to Hot  Sensitivity when Biting/Chewing  Sensitivity to Sweets  Swollen/Tender Gums  Tumors/Growths |

**Are you happy with your smile?**  Yes No

**Do you wish to learn more about Smile Shapers (like Invisalign)?**  Yes No

**In office teeth whitening? At home teeth whitening?**  Yes No

Is there anything not listed that you think we should know about you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **AUTHORIZATION**  I acknowledge that I have answered the above questions correctly and to the best of my ability. All my questions regarding this form have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If I ever have any changes in my health or medications, I will inform the dentist at the next appointment.  **Print Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature of Patient, Parent, or Guardian** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_ |

**CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION**

**& PRIVACY PRACTICES**

**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 is available for review at our office. 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. These 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 revision of our Notice, at any time by contacting our office at:

|  |  |  |
| --- | --- | --- |
| Phone: (563) 355-6626  Fax: (563) 359-7636  1751 E. 54th St.  Davenport, IA 52807 | H  O  U  R  S | Mon 7:30-4 *(closed 12-12:30)*  Tues 9:10-6 *(closed 1-2)* Wed 7:30-4 *(closed 12-12:30)*  Thurs 7:10-1 |

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

|  |
| --- |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***[print name]***, have had full opportunity to read and consider the contents of this Consent form and the Dr. Martin Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information Dr. Martin to carry out treatment, payment activities and healthcare operations.  **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*If this Consent is signed by a personal representative on behalf of the patient, complete the following:*

**Personal Representative’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT**