JASON E. MARTIN, DDS, PA
GENERAL, COSMETIC, & IMPLANT DENTISTRY

Today's Date: _____

Patient Information:

Last Name: _____

First Name: _____ MI: _____

Date of Birth: _____ Age: _____

Gender: _____ Marital Status: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer/School Name: _____

Occupation: _____

Phone (Home): _____ (Cell): _____

(Work): _____ Ext: _____

Email: _____

Spouse's Name _____

Whom may we thank for referring you to our practice?

_____

In case of an emergency contact:

Name: _____ Phone: _____

Relationship: _____

Insurance Information:

Primary Insured's Information

Name: _____

Birth Date: _____ ID/Social Security# _____

Group# _____ Employer Name: _____

Relationship to Patient: _____

Insurance Plan Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Secondary Insured's Information

Name: _____

Birth Date: _____ ID/Social Security# _____

Group# _____ Employer Name: _____

Relationship to Patient: _____

Insurance Plan Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Responsible Party Information

Person Responsible for Account: (Print Name) _____

I accept responsibility for payment of all dental services rendered in this office for myself and my dependents regardless of what insurance benefits may apply. Payment is due at the time of service and I understand that financial arrangements MUST be made prior to dental appointments. Assignment of insurance benefits, if applicable, is a courtesy extended to me and does not replace my responsibility for all charges incurred. Your signature will also allow us by law to prepare your insurance forms and assist in making collections from insurance companies to credit your account.

Patient/Responsible Party: (Signature): _____ Date: _____

HITECH ACT

The federal Red Flag Law requires all healthcare practices to obtain, verify, and record information that identifies every patient (new & existing). A digital photo will be taken at your appointment to be used as a permanent record of your identity.

Health History

Do you have or have you ever had any of the following? Please circle YES or NO:

Y N AIDS/HIV	*Y N Thyroid Disease*	*Y N Osteoporosis*
Y N Alzheimer's Disease	*Y N Blood Disease*	*Y N Respiratory Problems*
Y N Psychiatric Care	*Y N Blood Pressure*	*Y N Asthma*
Y N Are you pregnant	*High or Low*	*Y N Tuberculosis*
Due Date _____	*Y N Blood Thinners*	*Y N Herpes*
Y N Artificial Joints	*Y N Blood Transfusion*	*Y N Ulcers*
Y N Artificial Heart Valve	*Y N Prolonged Bleeding*	*Y N Drug Dependency*
Y N Congenital Heart Defects	*Y N Hepatitis*	*Y N Sensitivity to Epinephrine*
Y N Previous Infective	*Type A/B/C*	*Y N Allergy: Penicillin*
Endocarditis	*Y N Anemia*	*Y N Allergy: Latex*
Y N Pacemaker	*Y N Sickle Cell Anemia*	*Y N Allergy: Sulfa Drugs*
Y N Cancer	*Y N Diabetes*	*Y N Allergy: Ibuprofen*
Y N Chemotherapy	*Type: I or II*	*Y N Allergy: Aspirin*
Y N Radiation Therapy	*Y N Liver Disease*	*Y N Allergy: Codeine*
Y N Epilepsy/Seizures	*Y N Jaundice*	*Other Allergies: _____*
Y N Fainting	*Y N Kidney Disease*	*_____*
Y N Stroke	*Y N Lung Disease*	*_____*

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING: *(Attach list for additional medications)*

_____

_____

Y N Do you smoke or chew tobacco? (Type and how much):_____

Y N Have you ever had any complications following dental treatment? Explain:_____

Y N Have you been admitted to a hospital or needed emergency care during the past two years? Explain:_____

_____

Y N Are you currently under the care of a physician? Explain:_____

Name of Physician:_____ Phone number:_____

Y N Have you ever used a bisphosphonate medication? Common brands are Fosamax, Actonel, Atelvia, Didronel and Boniva.

Y N Do you have any health problems that need further clarification? Explain:_____

_____

Dental History

Reason for today's visit:_____

Name of previous Dentist: _____ Date of last Dental visit: _____ Date of last x-rays:_____

How often do you brush?_____ How often do you floss?_____

Y N Do your gums bleed when you brush? _____

Y N Have you ever been treated for periodontal disease (deep cleaning, bone grafting, etc.)? _____

Y N Do you have pain when chewing? _____

Y N Do you grind or clench your teeth? _____

Y N Do you have a biteguard? _____

Y N Do you have any loose or cracked teeth? Where?_____

Y N Do you have any missing teeth? Where?_____ Replaced?_____

Y N Have you ever had a cold sores/fever blisters? How often?_____

Y N Have you ever had orthodontic treatment? If yes, when?_____ Doctor's name_____

What would you like to change about you smile?_____