Luis E. Martinez, D.M.D., P.A.

"Museum Quality Dentistry"

To my patients,

So that we may provide you with the best possible state of the art esthetic services available, I often feel it is necessary to take photographs and study models. I would appreciate you taking the time to read and sign this consent form.

Thank you,
Dr. Luis Martinez

Please Read This Form Before Signing:

Name:_____ **Date:**_____

I hereby give permission to Dr. Luis Martinez, or any staff he may designate, to take photographs and study models for diagnostic purposes and to enhance the dental record. I agree that these photographs will remain the property of Dr. Luis Martinez.

Date:_____ **Signature:** _____

I further authorize him to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures, if in his judgment dental research, education, or science will be benefited by their use. Patient photographs may also be used for illustration purposes when previewing types of esthetic dental treatment with other patients. It is specifically understood that in any such publication or use I shall not be identified by name.

Date:_____ **Signature:** _____
(Patient or person authorized to give consent of the patient)

I further give permission to Dr. Martinez to display full face portraits for the purposes of illustrating or marketing various esthetic dental problems. These displays may include the dental office and/or public marketing in print or media.

Date:_____ **Signature:**_____
(Patient or person authorized to give consent of the patient)

3770 16th Street North • St. Petersburg, Florida 33704
727-526-3868 • 727-525-1224
www.stpetecosmeticdentistry.com

Welcome

Please fill out this form completely, it is important to your care.

ABOUT YOU

Today's Date: _____ ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Name: _____ (LAST / FIRST / MI) ☐ M ☐ F Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____ (CITY / STATE / ZIP)

Hm #: (_____) _____ Cell #: (_____) _____ Wk #: (_____) _____ DL #: _____

E-Mail Address: _____ When are the best times to reach you? _____

Whom may we thank for referring you? _____ Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____ (CITY / STATE / ZIP)

General Doctor: _____ Previous or Present (Please circle) Date of last visit: _____

In the event of an emergency, whom should we contact?

His/Her Name: _____ Relation: _____ Wk #: (_____) _____

Hm #: (_____) _____ Address: _____ (CITY / STATE / ZIP)

SPOUSE INFORMATION

His/Her Name: _____ Birthdate: ___/___/___ SS #: _____

Employer: _____ Wk #: (_____) _____ DL #: _____

Person Responsible for Account, if other than yourself

Name: _____ Relation: _____ SS #: _____

Employer: _____ Wk #: (_____) _____ DL #: _____

Hm #: (_____) _____ Billing Address: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage: ☐Y ☐N Medical Coverage: ☐Y ☐N Orthodontic Coverage: ☐Y ☐N

Insurance Co. Name: _____ Ins. Co. Ph #: (_____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____ (CITY / STATE / ZIP)

Insured's Name: _____ Relation: _____ Insured's Birthdate: ___/___/___ SS #: _____

Insured's Employer: _____ Employer's Address: _____ (CITY / STATE / ZIP)

Secondary Insurance Dental Coverage: ☐Y ☐N Medical Coverage: ☐Y ☐N Orthodontic Coverage: ☐Y ☐N

Insurance Co. Name: _____ Ins. Co. Ph #: (_____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____ (CITY / STATE / ZIP)

Insured's Name: _____ Relation: _____ Insured's Birthdate: ___/___/___ SS #: _____

Insured's Employer: _____ Employer's Address: _____ (CITY / STATE / ZIP)

HISTORY

Why have you come to the doctor today? _____

_____

Are you currently in pain? ☐ Y ☐ N

Do you require antibiotics before dental treatment? ☐ Y ☐ N

Have you experienced problems associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw (TMJ / TMD)? ☐ Y ☐ N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Y ☐ N Do you brush daily? ☐ Y ☐ N

Type of bristles on toothbrush: ☐ Hard ☐ Medium ☐ Soft

How often do you replace your toothbrush? _____

Do you use anything in addition to your brush and floss? ☐ Y ☐ N

If yes, what? _____

Would you like fresher breath? ☐ Y ☐ N Whiter teeth? ☐ Y ☐ N

Do your gums bleed? ☐ Y ☐ N Do gums itch? ☐ Y ☐ N

Have you ever had periodontal disease? ☐ Y ☐ N

Do you have mobility in your teeth? ☐ Y ☐ N

Are your teeth sensitive to heat, cold or anything else? _____

Do you still have wisdom teeth? ☐ Y ☐ N

If yes, why? _____

Previous Doctor: _____ Date of last visit: _____

Why did you leave your previous dentist? _____

What did you like most / least about any dentist you have seen?

_____

Are you happy with the way your smile looks? ☐ Y ☐ N

If not, what would you change? _____

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: _____

Address: _____

Phone #: (_____) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Do you smoke or use tobacco in any form? ☐ Y ☐ N

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs / materials that cause allergic reactions:

_____ _____

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Pressure Medication	Y N Recreational Drugs
Y N Antibiotics	Y N Cold Remedies	Y N Steroids / Cortisone
Y N Antihistamines	Y N Digitalis / Heart Medication	Y N Thyroid Medicine
Y N Aspirin	Y N Insulin / Diabetes Drugs	Y N Tranquilizers
Y N Blood Thinners	Y N Nitroglycerin	

Have you ever taken Phen-Fen (Redux or Pondimin)? ☐ Y ☐ N

Have you ever taken Fosamax or any other bisphosphonate? ☐ Y ☐ N

Are you currently taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ☐ Y ☐ N

If yes, please list each one _____

_____

WOMEN: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Unsure ☐ Y ☐ N Week #_____

Are you nursing? ☐ Y ☐ N

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Artificial Bones / Joints	Y N Drug Abuse	Y N Hemophilia	Y N Osteoporosis	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fever Blisters	Y N HIV+ / AIDS	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for Any reason	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Scarlet Fever	Y N Venereal Disease

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

My method of payment will be _____.

_____ _____

SIGNATURE DATE

PAYMENT IS DUE AT TIME OF SERVICE.

I certify that I am covered by _____ Insurance Co.

and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

SIGNATURE DATE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Dr. Luis E. Martinez, D.M.D., P.A.

Financial Expectations and Responsibility Agreement

Thank you for choosing our office as your dental care provider. We are committed to providing you the best technology available for diagnosing and treating your dental care needs in a safe and comfortable environment.

The following explanation is intended to promote a better understanding of our financial expectations and to develop a comfortable relationship between patient and doctor. Prior to starting any treatment with Dr. Martinez, you are required to read and sign this Financial Expectations and Responsibility Agreement.

After a complete comprehensive evaluation, Dr. Martinez will present an explanation of his findings. You will then be presented with a detailed treatment plan and be given an estimated fee for the proposed dental treatment. Dr. Martinez will gladly answer any questions you may have regarding your treatment. Our Financial Coordinator will discuss payment options to assist you in fulfilling your financial obligations.

Payment Options~

- Cash
- Personal Checks
- Visa, MasterCard, Discover, American Express
- Outside Financing: We participate with a company that will finance your dental work with approved credit. This allows you to complete your dental work without delay and make relatively small monthly payments. Some of the plans, depending on the amount and length of time financed, provide a no-interest, same-as-cash benefit. Our Financial Coordinator will be happy to help you by answering any questions and provide you with appropriate application information. We only accept this outside financing for treatment exceeding $3000.

Patients with Dental Insurance~

Dr. Martinez is a "non-participating provider" – this means that he is not contracted with ANY insurance company. **We do not accept assignment of benefits.** It is your responsibility and obligation to verify your insurance coverage and assume responsibility for payment of all procedures you elect to have done. We cannot render services on assumption the charges will be paid by an insurance company. Dental insurance benefits are provided to you through an agreement between your insurance company and the subscriber's employer. It is a benefit to you from the insurance company, to reimburse you for portions of your payment at our office. Ultimately, you are responsible for full payment of all charges on your account. We expect payment on the day services are rendered. As a courtesy, and to expedite reimbursement, we will file your insurance claims for you. At your request, we will be glad to submit a pre-determination of dental benefits prior to major treatment.

Patients without Dental Insurance~

Payment for all procedures is due at the time of service. Prior to starting major reconstructive and/or cosmetic treatment, our Financial Coordinator will discuss a payment schedule for these procedures.

Dental treatment is unique to each patient and a complete understanding of your treatment and scheduled appointments is very important. Our Financial Coordinator will discuss payment options to assist you in fulfilling your financial obligations.

Reserved Appointment Protocol~

In keeping with the philosophy of devoting our time to one patient at a time, we ask that you respect the importance of the appointment we have reserved for you. In the event that you cannot be present for your reserved appointment, we ask that you give us at least 48 hours advance notice. Any cancellations less than the requested 24 hours will incur a charge on your account that must be paid before rescheduling another appointment. The fees for this are as follows:

Routine Appointment with the Dental Hygienist ~ $75
Root Planing Appointment with the Dental Hygienist ~ $175
Consultation/Evaluation Appointment with Dr. Martinez ~ $80
Restorative Appointment with Dr. Martinez ~ $125 - $250

I understand that I am responsible for payment at the time services are rendered and am responsible for the above listed fees if I or anyone on my family account do not give the requested notice when canceling or rescheduling an appointment. If I have dental insurance, I hereby authorize Dr. Martinez to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to the insured person, whether or not that is me.

Patient	Signature of Responsible Party	Date

Dr. Luis E. Martinez 3770 16th Street North St. Petersburg, FL 33704

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

We are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by another doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, for quality assessment and improvement activities, conducting training programs, and licensing activities.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call, text, or email and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner. Your health information will not be sold in any other manner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you. You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will post the new notice clearly and prominently at our practice location, on our website, and we will provide copies of the new notice upon request

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer at (727) 526-3868 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment of Receipt of Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the office of Dr. Luis E. Martinez . A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____

Patient's Name (please print)

_____

Signature of patient or guardian

_____

Date

Medical Information May Be Shared With Family and or Persons Listed

_____

_____

_____

_____

Dr. Luis E. Martinez
3770 16th St. N.
St. Petersburg, Fl. 33704

SLEEP SCREENING QUESTIONNAIRE

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze **1 = Slight chance of dozing**
2 = Moderate chance of dozing **3 = High chance of dozing**

SITUATION	
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (i.e. theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

A score of 8 or greater indicates the possibility of sleep disordered breathing.

THORNTON SNORING SCALE

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her, both physically and emotionally. Use the following scale to choose the most appropriate number for each situation. (Go to the 4th statement if you have no bed partner.)

0 = Never **1 = Infrequently (1 night per week)**
2 = Frequently (2-3 nights per week) **3 = Most of the time (4 or more nights per week)**

My snoring affects my relationship with my partner	_____
My snoring causes my partner to be irritable or tired	_____
My snoring requires us to sleep in separate rooms	_____
My snoring is loud	_____
My snoring affects people when I am sleeping away from home (i.e. hotel, camping, etc.)	_____
TOTAL SCORE	_____

A score of 5 or greater indicates your snoring may be significantly affecting your quality of life.