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

Health History Form

Patient Information

Name: Last First Middle **Nickname** Today's Date:

Address: City State Zip

Home phone: Work phone: Cell Phone:

Email address: Best time and manner to contact you:

Date of birth: | Sex: ☐ M ☐ F | Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Partnered ☐ Widowed | SS#:

Employer: Occupation:

Emergency Contact Name: Phone: Relation:

Who may we thank for referring you?

Dental Information- Please mark (X) for your responses to the following questions

	Yes	No		Yes	No
Do your gums bleed when you brush or floss?	☐	☐	Do you have earaches or neck pain?	☐	☐
Are any of your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐
			Do you brux or grind your teeth?	☐	☐
Does food or floss catch between your teeth?	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐
Is your mouth dry?	☐	☐	Do you wear dentures or partials	☐	☐
Have you had any periodontal (gum) treatment?	☐	☐	Do you participate in active recreational activities?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐
Have you had any problems w/ previous dental treatment?	☐	☐	Do you wear a CPAP or snoring device?	☐	☐

Do you drink bottled ☐ or filtered water ☐?

What is the reason for your dental visit today? _____

Date of your last dental exam: _____ Date of last dental x-rays? _____

Are you currently experiencing dental pain or discomfort? ☐ ☐

If yes, please describe: _____

What was done at that time? _____

How do you feel about your smile?

_____

Medical Information- Please mark (X) for your responses to the following questions

	Yes	No		Yes	No
Are you now under the care of a physician?	☐	☐	Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐
Physician Name: Phone:			If yes, what was the illness or problem?		
Address/City/State/Zip:			Are you taking any prescription or over the counter medicine(s)?	☐	☐
Are you in good health?	☐	☐	Please list all prescribed, over the counter and diet supplements:		
Has there been any change in your general health within the last year?	☐	☐			
If yes, what condition is being treated?					
Date of last physical exam:					

Medical Information- Please mark (X) for your responses to the following questions

Joint Replacement- Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ☐ No ☐
Date: _____
If yes, have you had any complications?
_____

Are you taking, scheduled to begin, or taken in the past either of the medications, alendronate (Fosomax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐
Were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐
Date treatment began: _____

	Yes	No
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)		
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ☐ ☐
Name/Phone: _____

Allergies- Are you allergic to or have had a reaction to:
To all **yes** responses, specify type of reaction.

Dental anesthetics _____	☐	☐	Sulfa drugs _____	☐	☐
Aspirin _____	☐	☐	Codeine or other narcotics _____	☐	☐
Penicillin _____	☐	☐	Metals _____	☐	☐
Other antibiotics _____	☐	☐	Latex (rubber) _____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	Hay fever/seasonal _____	☐	☐
			Food _____	☐	☐
			Other _____	☐	☐
			_____		

Do you use controlled substances (drugs)? ☐ ☐
Do you use tobacco(smoking, snuff, chew, bidis)? ☐ ☐
If so, how interested are you in stopping?
(Circle one) VERY/ SOMEWHAT/ NOT INTERESTED
Do you drink alcoholic beverages? ☐ ☐
If yes, how much do you typically drink in a week? _____

Women only- Are you: ☐ ☐
Pregnant?
If so, number of weeks: _____
Taking birth control pills? ☐ ☐
Taking hormonal replacement? ☐ ☐
Nursing? ☐ ☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No		Yes	No		Yes	No
Cardiovascular disease	☐	☐	Arthritis	☐	☐	Stroke-	☐	☐
Angina	☐	☐	Autoimmune disease	☐	☐	If yes, date: _____		
Arteriosclerosis	☐	☐	Rheumatoid arthritis	☐	☐	Hepatitis, jaundice or liver disease	☐	☐
Congestive heart failure	☐	☐	Systematic lupus erythematosis	☐	☐	Epilepsy	☐	☐
Damaged heart valves	☐	☐	Asthma	☐	☐	Fainting spells or seizures	☐	☐
Heart attack-	☐	☐	Bronchitis	☐	☐	Neurological disorders	☐	☐
If yes, date: _____			Emphysema	☐	☐	Specify: _____		
Hear murmur	☐	☐	Sinus trouble	☐	☐	Sleep disorders	☐	☐
Low blood pressure	☐	☐	Tuberculosis	☐	☐	Mental health disorders	☐	☐
High blood pressure	☐	☐	Cancer/Chemotherapy/Radiation	☐	☐	Specify: _____		
Other congenital heart defects	☐	☐	treatment			Recurrent infection	☐	☐
Mitral valve prolapse	☐	☐	Xerostomia (dry mouth)	☐	☐	Specify: _____		
Pacemaker	☐	☐	Chest pain upon exertion	☐	☐	Kidney problems	☐	☐
Rheumatic fever	☐	☐	Chronic pain	☐	☐	Night sweats	☐	☐
Rheumatic heart disease	☐	☐	Diabetes Type I or II	☐	☐	Osteoporosis	☐	☐
Abnormal bleeding	☐	☐	Eating Disorder	☐	☐	Persistent swollen glands in neck	☐	☐
Anemia	☐	☐	Gastrointestinal disease	☐	☐	Severe headaches/migraines	☐	☐
Blood transfusion-	☐	☐	Acid reflux/persistent heartburn	☐	☐	Severe or rapid weight loss	☐	☐
If yes, date: _____			Ulcers	☐	☐	Sexually transmitted disease	☐	☐
Hemophilia	☐	☐	Thyroid problem	☐	☐	Excessive urination	☐	☐
AIDS or HIV infection	☐	☐	Glaucoma	☐	☐	Fibromyalgia	☐	☐

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐
Please explain: _____

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Martinez and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Martinez, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

Signature of Patient/Legal Guardian: **Date:**

_____

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 24 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 ~ $70
Root Planing Appointment with the Dental Hygienist ~ $175
Consultation/Evaluation Appointment with Dr. Martinez ~ $40
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 (813) 251-0770 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.

PATIENT NAME _____ **DATE:** _____