MARTIN DENTISTRY
Dax F. Martin DDS — Douglas M. Martin DDS — Sky O. Martin DDS
1310 East Swain Rd.Ste 2, Stockton, Ca. 95210
209-951-4251

Who may we thank for referring you?_____

Do we see any of your friends or relatives?_____

Have you seen our web site **www.martinimplants.com**? Yes No

PATIENT INFORMATION — PLEASE PRINT

Name_____Birthdate_____

Address_____City_____State____Zip_____

Telephone Home#( )_____Work#( )_____Cell #( )_____

SS#_____ Driver's License #_____ Email _____

Patient's employer_____Address_____

Position/Title_____How long?_____

Student? Yes No – If yes, name of school_____

S___M___D___W____Spouse's name_____SS#_____D.O.B._____

Spouse's employer_____Address_____

Position/Title_____How long?_____

Emergency contact_____Phone#( )_____

IF A CHILD:

1st Parent / Guardian name _____D.O.B._____SS#_____

Parent / Guardian address _____City_____State____Zip_____

Phone#( )_____Employed by_____Work#( )_____

2nd Parent / Guardian name _____D.O.B._____SS#_____

Parent / Guardian address _____City_____State____Zip_____

Phone#( )_____Employed by_____Work#( )_____

If Guardians, relationship: 1st:_____ 2nd:_____

Who will be responsible for payments_____

DO YOU HAVE A DENTAL BENEFIT PLAN?

PRIMARY DENTAL BENEFIT INFORMATION:

Employee covered by dental benefits _____D.O.B._____

Employee SS#_____ Work # ( ) _____

Dental Benefit Company _____Group Number_____

Dental Benefit Co. address _____

Dental Benefit Co. phone# ( )_____

SECONDARY DENTAL BENEFIT INFORMATION:

Employee covered by dental benefits _____D.O.B._____

Employee SS# _____Work # ( ) _____

Dental Benefit Company _____Group Number_____

Dental Benefit Co. address _____

Dental Benefit Co. phone# ( )_____

OVER

Are you having pain or discomfort now? ..... YES NO
If you are having pain, were you able to sleep last night? ..... YES NO
Have you been a hospital patient in the last two years? ..... YES NO
Have you been under the care of a medical doctor in the past two years? ..... YES NO

Physicians name_____ Address_____Phone# ( )_____
Have you taken any medication or drugs in the past two years? ..... YES NO
Are you now taking any medications or drugs? ..... YES NO
Fosamax or Biphosphanates YES NO Cortisone or Steroids YES NO Diet drugs such as Phenfen YES NO
Please list other drugs:_____
_____
Are you allergic to or sensitive to any drugs or medications ..... YES NO
If yes, please list:_____

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

heart failure	YES NO	diabetes	YES NO	arthritis	YES NO
heart attack or disease	YES NO	ulcers	YES NO	osteoporosis	YES NO
angina pectoris	YES NO	thyroid problems	YES NO	artificial joints	YES NO
congential heart disease	YES NO	glaucoma	YES NO	auto-immune disease	YES NO
endocarditis	YES NO	epilepsy or seizures	YES NO	H.I.V.positive	YES NO
artificial heart valve	YES NO	cancer	YES NO	A.I.D.S	YES NO
heart pacemaker	YES NO	tumors	YES NO	veneral disease	YES NO
heart surgery	YES NO	radiation therapy	YES NO	cold sores or fever blisters	YES NO
arteriosclerosis	YES NO	chemotherapy	YES NO	dry mouth	YES NO
stroke	YES NO	emphysema	YES NO	bruise easily	YES NO
high blood pressure	YES NO	chronic cough	YES NO	fainting or dizzy spells	YES NO
kidney problems	YES NO	tuberculosis	YES NO	nervousness	YES NO
liver disease	YES NO	sinus trouble	YES NO	drug addiction	YES NO
hepatitis A, B or C	YES NO	asthma	YES NO	allergies or hives	YES NO
hemophilia	YES NO	hay fever	YES NO	allergy to iodine	YES NO
anemia	YES NO	sickle cell disease	YES NO	allergy to latex	YES NO
blood tranfusion	YES NO	developmental disability	YES NO	gums bleed	YES NO

When you walk up stairs, do you ever have to stop because you are tired or have pain in your chest? ..... YES NO
Do you have urinate 3 or more times a night? ..... YES NO
Do you use more than one pillow to sleep on? ..... YES NO
Have you gained or lost more than ten pounds in the last year? ..... YES NO
Do you ever wake and feel short of breath? ..... YES NO
Are you on a special diet? ..... YES NO
Do you have any disease or condition or problem not listed? ..... YES NO
If yes, please tell us._____
Do you smoke? YES NO **Have you ever been a smoker?** YES NO If yes, when did you quit? _____
Do you use other tobacco products (snuff, chewing tobacco)? YES NO
Do you take vitamins regularly? YES NO If so what?_____

For women only: Is there a possibility you may be pregnant? YES NO If yes, what month? _____ Are you nursing? YES NO.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient or Guardian's signature _____ date _____

Consent:

I authorize Martin Dentistry to take xrays, study models, photographs, or any other diagonostic aids deemed appropriate to make a thorough diagnosis. I authorize and consent that Martin Dentistry may choose and employ such assistance as deemed fit to provide the recommended treatment.

I authorize Martin Dentistry to obtain medical and dental records from any previous or current health care providers. I also authorize Martin Dentistry to release any information acquired in the course of treatment to benefit providers and to recieve assignment of benefits.

I authorize Martin Dentistry to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with _____ (name of patient).

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangement have been made. In the event payments are not recieved by the agreed upon times, I understand that a 1.5% per month finance charge on the unpaid balance may be added to my account, in addition to any collection charges. I understand that when appropriate, credit reports may be obtained.

Patient or guardian of patient _____ date _____ witness _____

Doctor date and initial: _____ recall _____ recall _____ recall _____ recall _____

MARTIN DENTISTRY

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(209) 951-4251

MARTIN DENTISTRY wants to work with with you to provide you with the best experience at our office.

This is an agreement between MARTIN DENTISTRY and _____.

Awareness of my responsibility: I agree to be responsible to pay in full the entire amount charged for dental services provided for me, and for any dependent persons on my account by MARTIN DENTISTRY. I understand that even though there may be a dental benefit or insurance plan in place, I am still responsible for the entire amount due to MARTIN DENTISTRY.

Time payments become due: I agree to pay for services provided to me as soon as they have been rendered unless alternative arrangements have been made. Co-pays on plans that require them are due before work can be started. I understand that MARTIN DENTISTRY, at its sole discretion, may agree to enter into alternative payment arrangements with me and that such separate agreements DO NOT constitute a waiver of or alter the provisions of this agreement except as explicitly stated in that alternate agreement.

Payment for services: I understand that the amount I owe will be reduced by any payments received by MARTIN DENTISTRY from any dental benefit plan or insurance made on my behalf, and that I will only be responsible for the unpaid balance left after any such payments are made. Furthermore, I understand I am responsible to make such claims to any benefit and insurance plans that may be in place. Although MARTIN DENTISTRY will submit claims on my behalf, as a courtesy, I understand that it is not an obligation of MARTIN DENTISTRY to submit such claims.

Authorizing information release: By signing this agreement, I specifically agree to authorize MARTIN DENTISTRY to submit any such claims on my behalf and to submit any medical, dental, and identification information required by my insurance or benefit plan to expedite the processing of my claim.

Authorizing payment to MARTIN DENTISTRY from my benefit plan or insurance: By signing this agreement, I hereby direct my benefit plan or insurance company to issue payment directly to MARTIN DENTISTRY on my behalf to pay for services that I have received from MARTIN DENTISTRY.

Cancellations and missed appointments: If I cannot keep an appointment, I agree to notify MARTIN DENTISTRY 48 hours in advance to allow them an opportunity to fill the time slot. If I miss any appointment that I have not cancelled in a timely manner, I agree to pay a cancellation fee of $50. (If your cancellation is beyond your control, please call and talk to us.)

Defaulting on payment: If I fail to pay for the services rendered to me or my dependents on my account when due, I agree to pay interest at the rate of 1.5% per month on any outstanding balance, or a billing fee of $5, whichever is greater. I also agree to pay reasonable attorney fees, collection expenses, and court costs in the event my account is referred to collection or other legal means are taken to recover any money owed.

If I have any problems: I agree to call MARTIN DENTISTRY and talk to your staff about it at:
(209) 951-4251.

I agree to everything stated above this _____ day of _____, 20_____.

_____ Signature of Patient or responsible party

_____ Signed for MARTIN DENTISTRY by