SMILES OF ORLANDO
CENTER FOR ADVANCED DENTISTRY

JAVIER E. MARTINEZ DDS, MS
PROSTHODONTIST

Personal Information

Patient ______________________ SSN# ______________
Address ______________________
City, State, Zip ______________________
Home Phone# ______________ Cell Phone# ______________
Birthdate ________ Age ____ Email ______________
Marital Status: ___Married ___Single ___Divorced ___Widowed

Responsible Party

Name ______________________ SSN# ______________
Address ______________________
City, State, Zip ______________________
Home Phone# ______________ Cell Phone# ______________
Birthdate ________ Email ______________
Business Phone ______________ Ext ________

Dental Benefit Information

Primary Cardholder ______________________
Occupation ______________ Employer ______________
Insurance Company ______________________
Policy# ______________ Group # ______________
Claim Address ______________________
City, State, Zip ______________
Phone# ______________

Getting to know you

Is another friend, relative in our office? ______________
Whom may we thank for this referral? ______________
Emergency Contact ______________ Phone# ______________

Assignment of Benefits

I hereby authorize assignment of my insurance benefits directly to Dr. Martinez for services rendered. I fully understand I am solely responsible for my balance not paid by my insurance company.)

Signature: ______________________ Date: ________

This is to certify that I, undersigned, consent to the performing of dental and oral surgery procedures to be necessary or advisable, including local anesthesia as indicated.

Signature: ______________________ Date: ________

I have read and understood this office 's Notice of Privacy Policy (HIPPA)

Signature: ______________________ Date: ________

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Medical History

1. What is the estimate of your general health? O POOR O FAIR O GOOD O EXCELLENT
2. Have you been hospitalized in the last 2 years? O YES O NO

Reason: ______________________________

3.Are you currently under the care of a physician? O YES O NO

If yes, please write name and number of physician or health care professional:

____

4. Does your dental visit make you nervous? O YES O NO

If yes, are you interested in Nitrous Oxide? O YES O NO

5. (Females) Are you currently pregnant? O YES O NO
6. Do you currently take any medications? If yes, please list:

____

7. Are you currently taking any blood thinners? O YES O NO
8. Have you taken any of the following medications? O YES O NO

Fosamax, Reclast, Actonel, Boniva, Aredia, Skelid, Aclasta, Didronel, Zometa

Circle any of the following which you have had or have at the present :

Psychiatric Care
Tuberculosis
Emphysema/ Bronchitis
Asthma/ Wheezing
Persistent Cough
Pheumatic Fever
Heart Murmur
Chest Pain
Heart Attack
Shortness of Breathe
Prolasped Mitral Valve
High Blood Pressure
Low Blood Pressure

Congenital Heart Disease
Heart Surgery
Pacemaker Kidney Disease
Kidney Transplant/Dialysis
Herpes
Easy Bruising/ Excessive Bleeding
Persistent Swollen Glands
Blood Transfusion
Hemophilia
Anemia/Sickle Cell
HIV positive Aids
Diabetes
Thyroid Problems

Radiation /Chemotherapy
Tumors or growth
Cancer
Alcohol Use
Tobacco Use
Epilepsy/Seizures/Convulsions
Neuralgia
Paralysis
Arthritis/Rheumatism
Artificial Joint
Muscle Weakness
Hepatitis or Jaundice
Ulcers

Are you allergic or have reacted adversely to any of the following?: (Please circle)

Local anesthetics (novocaine) Barbiturates, sedatives, sleeping pills
Penicillin or other antibiotics Sulfa drugs Aspirin Codeine Latex Products
Other: ______________________________

Dental History (please circle the ones that pertain to you)

Dental Pain
Bleeding Gums/Periodontal Disease
Blisters/Ulcers/Cold Sores
Swelling/Lumps in Mouth
White Coating on Tongue/Throat

Clicking/Popping Jaw
Difficulty Open/Close Jaw
Pain in or near ears
Sinus Trouble
Injury on Face/Jaw

Surgery on Face/Jaw
Sensitive Teeth
Clenching/Grinding Teeth
Loose Teeth

To the best of my knowledge, all answers are true and correct. If I ever have a change in health, or if my medicines change, I will inform Dr. Martinez at the next appointment.
Signature: ______________________________ Date: ______________

NOTICE OF PRIVACY POLICY

At our office we reasonably safeguard protected health information from any intentional or unintentional use or disclosure that violates the privacy law.

Patient's charts, x-rays insurance information etc, are stored in areas well away from patient access and flow. Any material that is outdated and requires destruction is destroyed in a manner (i.e. shredding) so that no information is retained or further obtainable or legible. If this practice is sold, your information will become the property of the new owner.

By law, we are permitted to use or disclose your health information to those involved in your treatment such as another specialist reviewing your file. In an emergency, we may disclose your health information to a family member or another person responsible for your care. If required by law, we may release some or all of your health information. 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 your health information as described above. We will attempt to fulfill your request.

We may use or disclose your health information for payment for your services. For example, if you have insurance coverage and our office submits claims for you, your insurance company will be given access to the appropriate information in regards to your dental claim and payment. This may include x-rays, medical information, dental information, personal information etc. Operatory rooms are angled in such way that privacy is preserved. Sign in sheets must not display the reason the patient has an appointment.

During telephone conversations, discussions regarding dental care are limited to the patient to whom the procedure was performed or parent or guardian in case the patient is a minor. We may use your information to contact you. Please be advised that phone messages will be left on answering machines, but also that messages left concerning upcoming appointments are brief and only state the necessary information to confirm/ remind of an upcoming appointment. Please provide us with telephone numbers, which you are comfortable with us contacting and messaging. We may also provide you with appointment reminders such as postcards. Patient charts are allowed access by the entire staff to ensure proper provision of treatment; this includes the front desk staff, which requires access as necessary to obtain payment. Staff members who violate the privacy policy will be subjected to disciplinary actions. Privacy is a very important matter to our office if at any time you would like more privacy or feel that your rights have been violated please inform our staff so that measures can be taken to your satisfactions.

You have the right to transfer copies of your health information to another practice. We will mail your files 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 also want a copy of your records, we may charge you a fee for the copies. You have the right to read our Notice Of Privacy Policy before you decide whether to sign this consent. You may refuse to sign this acknowledgement. Please sign the bottom indicating that you have read and understand this privacy policy notice. If you wish to keep a copy of this notice, please ask at the front desk and they will provide you with one.
Acknowledgement: I have received a copy of the Notice of Privacy Practices.

X ______________________________ ______________________________ ____________
Signed Print Name Date

If signing as a parent or guardian, please note the name of patient X ______________________________

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407-656-8080

Financial Policy

At SMILES OF ORLANDO, the office of Dr. Javier E. Martinez, the philosophy is to provide the best, most comprehensive treatment to all our patients and help them achieve optimum dental health, self-confidence and a beautiful smile. We are a practice that listens and educates our patients. In order to achieve these goals, we need your assistance, and your understanding of the following policy.

Dental Insurance

Please understand that most dental plans are designed to assist with limited treatment or routine maintenance and not designed to cover comprehensive treatment, regardless of the medical necessity. Treatment recommendations *are based on your health, not your insurance coverage*. *They are not concerned about your health or wellbeing* - ***we are.*** We will always inform you of the fees for any treatment you will receive in our office. We are happy to bill your insurance company as a courtesy to you. Although we will estimate what your insurance company will pay, it is the insurance company that makes the final determination of benefits. It is your responsibility to be aware of what your benefits are. You are responsible for any amount left unpaid by your insurance company. While your claim is being processed, you may receive monthly statements of your account. If you paid your estimated portion at the time of service, we do not expect payment from you unless your insurance has delayed payment over 60 days. We must emphasize that your insurance is a contract between you, your employer and the insurance company, not your doctor.

Payment Options

We accept cash, personal checks, and all major credit cards.

No interest/Extended payment plan

We offer extended financing through the third party financing company- Carecredit. Upon request, we will furnish you with all necessary information such as their rates and terms. If for any reason a refund needs to be given back to Carecredit card, it will be refunded back to that account. In some cases, we might have to charge a 10% administrative fee of the remaining balance.

We expect payment prior to or at the time treatment is provided. We reserve the right to charge interest of 1.5% per month to all balances over 90 days. If your account becomes delinquent, it will be forwarded to a collections attorney. If this becomes necessary, additional fees may be added to cover handling charges.

Cancellation Policy

We respect that your time is valuable as is the time of all our patients. *Should you need to cancel or reschedule an appointment*, ***we require* 2 business days notice** so we can give another patient your time slot. Please note that canceling less than 24 hours in advance, or arriving more than 15 minutes late may result in a cancellation fee of $50 for hygiene appointments and $125 for appointments with Dr. Martinez. After a second missed appointment, you may only be able to book as same-day or walk-in, which are subject to availability. This policy ensures that all our patients receive the dental care they need. Thank you for your understanding. ___________ (initial)

x____ ___________________
Signature of Patient or Responsible Party Date

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Patient Photo Authorization and Release

By signing the following form, the patient authorizes Javier Martinez D.D.S., M.S. and/or his designee (s) of Smiles of Orlando, to take oral photographs of me (or my child) for the following purposes (mark the following):

Medical Records	full face___	only teeth___	do not consent___
Treatment Planning	full face___	only teeth___	do not consent___
Educational Purposes	full face___	only teeth___	do not consent___
Marketing/ promotional materials	full face___	only teeth___	do not consent___

I understand that these photographs may be used in various media and advertisements of Smiles of Orlando, including but not limited to (mark the following):

Print Publications	full face___	only teeth___	do not consent___
Online Publications	full face___	only teeth___	do not consent___
Website of Smiles of Orlando	full face___	only teeth___	do not consent___
Social Media	full face___	only teeth___	do not consent___
Educational presentations	full face___	only teeth___	do not consent___

Information disclosed and pursuant to community publication authorization may be subject to re-disclosure and may no longer be protected by HIPPA privacy regulations.

Initial the following:
I understand that neither I, nor any family member, will be identified by name in any publication.
_____ (initial)

I understand that photographs may portray features that shall make my identity recognizable.
_____ (initial)

I agree that these photographs may be used by Javier Martinez D.D.S., M.S. and/or his designee (s) of Smiles of Orlando without further consent or compensation to me. I understand that these photographs will become the property of Smiles of Orlando and may be retained or destroyed at their discretion and upon request, with my signature, I may obtain a copy. _____ (initial)

I understand that I have the right to revoke this authorization at any time without affecting any actions taken before my revocation. The form will expire twenty (20) years from the date signed below. _____ (initial)

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
_____ (initial)

All of my questions have been answered by the staff to my satisfaction and I release and discharge Javier Martinez D.D.S., M.S. from any and all claims, demands, or causes of action that I may have by reason of this authorization.

_____________________________________ _____________________
Patient/ Guardian Date