MATTHEW J. MARTIN D.D.S., MS., P.C.

PRACTICE LIMITED TO ENDODONTICS

106 N. COTTONWOOD DRIVE #B

RICHARDSON, TX 75080

(972) 783-8811 FAX (972) 680-1024

New Patient Information

Date_____

Patient Information

Mr. First Middle Last

Mrs.

Ms._____

Address_____City,State,Zip_____

Phone_____Mobile_____Work_____Phone_____

Email_____Sex_____Date of Birth_____

Social Security_____-_____-_____

Employer:_____Co. Address_____

City,ST,Zip_____Phone_____

Referred by_____

Emergency Contact_____Relation to you_____Phone_____

Dental Insurance PLEASE PROVIDE COPY OF INSURANCE CARD

Insurance Company_____Policy Holder Name:_____

Policy Holder's DOB_____SSN_____Phone number_____

Relationship to Member_____Member ID#_____Group#_____

Address_____City:_____State:_____Zip_____

Phone_____

Company Insurance is Provided through

Company Name_____Address_____

City,ST,Zip_____Phone_____

Responsibility and Consent Statement

I hereby authorize and request the performance of dental services for myself or for:

_____Age:_____

I also give my consent to any advisable and necessary dental x-rays, procedures, medications, or anesthetics to be administered by the dentist or by the supervised staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am financially responsible for the services provided for myself or the able named, regardless of insurance coverage. I hereby authorize the release of all information necessary to secure payment of benefits, I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature_____**Date**_____

Signature of Patient, Guardian, or Personal Representative

OVER

Medical History

Do you have any known health problems? ☐Yes ☐No If yes, explain_____
Have you been hospitalized in the last 5 yrs? ☐Yes ☐No If yes, explain_____
Are you under a physicians care now? ☐Yes ☐No If yes, explain_____
Do you have a pacemaker? ☐Yes ☐No
Are you pregnant? ☐Yes ☐ No If yes what month are you in?_____
Do you have a Prosthetic Heart Valve? ☐Yes ☐ No
Are you taking a prescription blood thinner? ☐Yes ☐ No
Are you allergic to any medications? ☐Yes ☐ No If yes, What?_____
_____
Are you taking any medications? ☐Yes ☐ No If yes, What?_____
_____
Medical Doctor_____Medical Doctor's Phone #_____

Have you ever had the following conditions? If no please mark this box ☐

☐ Heart Murmur	☐ Angina	☐ Asthma	☐ Latex allergy
☐ Heart Diseases	☐ Stroke	☐ HIV or AIDS	☐ Blood Diseases
☐ High Blood Pressure	☐ Seizure	☐ Sinus Trouble	☐ Ulcers
☐ Low Blood Pressure	☐ Arthritis	☐ Anemia (Blood Disease)	☐ Rheumatic Fever
☐ Mitral Valve Prolapse	☐ Diabetes	☐ Liver Disorder (Hepatitis)	☐ Kidney Disorder
☐ Congenital Heart Lesions	☐ Prosthetic Devices (knee, hip, etc.)		☐ Cancer

☐ Other _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ and assign directly to Dr. Matthew Martin all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

{Please Print Name}

_____

{Signature}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)_____

I certify that I have read and understand this form. I acknowledge that my questions, if any about the inquires set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient_____ **Date**_____
Signature of Dentist_____**Date**_____