



Luis E. Martínez, 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 Martínez

Please Read This Form Before Signing:

Name: _____

Date: _____

I hereby give permission to Dr. Luis Martínez, 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 Martínez.

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. Martínez 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)

WELCOME!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ Male Female

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____

APT / CONDO # _____

CITY _____

STATE _____

ZIP _____

2 Who Is Accompanying The Child Today?

Name: _____

Relation: _____

Do you have legal custody of this child? Yes No

Whom may we **Thank** for referring you: _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last visit date: _____

Parent's Marital Status: Single Married Widowed Divorced Separated

3 Mother's Information Step Mother Guardian

Name: _____ Birthdate: ____/____/____

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

Employer: _____

SS #: _____ Cell #: (____) _____

Father's Information Step Father Guardian

Name: _____ Birthdate: ____/____/____

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

Employer: _____

SS #: _____ Cell #: (____) _____

4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

DL #: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to patient: _____

Policy Owner's Birthdate: ____/____/____ ID #: _____

Policy Owner's Employer: _____

Orthodontic coverage? Yes No

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to patient: _____

Policy Owner's Birthdate: ____/____/____ ID #: _____

Policy Owner's Employer: _____

Orthodontic coverage? Yes No

CONTINUED ON BACK

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

Pediatric Airway Questionnaire

Please fill out this form as accurately and honestly as possible. It is documented that the mildest form of Sleep Disorder Breathing, SNORING, impairs neurobehavioral development! It is Important to screen children so that we can help them be the healthiest they can be.

Patient Name _____ Date ____/____/____

While sleeping, does your child snore more than half the time? _____

While sleeping, does your child always snore? _____

While sleeping, does your child snore loudly? _____

While sleeping, does your child have "heavy" or loud breathing? _____

While sleeping, does your child have trouble breathing, or struggle to breathe? _____

Have you even seen your child stop breathing during the night? _____

Does your child occasionally wet the bed, sleepwalk, or have night terrors? (circle any) _____

Does your child tend to breathe through the mouth during the day? _____

Does your child have a dry mouth on waking in the morning? _____

Does your child wake up unrefreshed in the morning? _____

Does your child wake up with headaches in the morning? _____

Is it hard to wake up your child in the morning? _____

Does your child have a problem with sleepiness during the day? _____

Has a teacher or supervisor commented "your child appears sleepy during the day?" _____

Did your child stop growing at a normal rate at any time since birth? _____

Is your child overweight? _____

This child does not seem to listen when spoken to directly _____

This child often has difficulty organizing tasks and activities _____

This child often is easily distracted by extraneous stimuli _____

This child often fidgets with hands or feet, or squirms in seat _____

This child often is "on the go" or often acts as if "driven by a motor" _____

This child often interrupts or intrudes on others (butts in conversations or games) _____

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 \$1000.00

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 48 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 ~ \$95
- Root Planing Appointment with the Dental Hygienist ~ \$195
- Consultation/Evaluation Appointment with Dr. Martinez ~ \$95
- Restorative Appointment with Dr. Martinez ~ \$195 - \$350

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

