The Martin Dental Center for Oral Health and Aesthetics

New Patient Registration / Today's Date______________

Full Legal Name_____________________________________Preferred__________________ Birth Date_____

Address____City________________ Zip Code_______

Phone Numbers: Home __________________ Work _________________Cell ____________________

E-Mail Address____

Social Security#:_____-_____-_____
Social Security# Head of Household (if different) _____-_____-_____
Employer____________________Position______________________
Marital Status Married ( ) Single ( ) Divorced ( ) Widowed ( )
If married, spouse's name________________Is spouse a patient? Y ( ) N ( )
List any other family members who are patients
____
Spouse's Employer___________________Position________________
Whom may we thank for your referral? ________________ How did you hear about us? ___________________
Do you have dental insurance? _____ Insurance Carrier___________________ Member ID_________________
Subscriber name_________________________ Birthdate____________
Which letter best describes you as a patient? ____

A: I am interested in optimum dental health and in only having the best dentistry done in my mouth in every instance of need.
B. I am interested in good dental care and in taking care of problems I might have, with different treatment options explained to me.
C. I am only interested in having certain dental problems taken care of in the most efficient, least expensive way.
D. If it doesn't hurt, don't fix it. If it does hurt let's decide why and discuss whether to fix it or not.

Do you have any questions or concerns about your dental health that we can answer today? What is the reason for your dental visit?

____
____
____
____

Please check the appropriate answers in the columns provided. YES NO

Do you have a history of any of the following:

Heart Disease__________________________________ ___ ___
Tuberculosis__________________________________ ___ ___
Diabetes_____________________________________ ___ ___
Thyroid Problems______________________________ ___ ___
Hepatitis (Jaundice) ___________________________ ___ ___
High Blood Pressure____________________________ ___ ___
Stroke or Arteriosclerosis_________________________ ___ ___
Sexually Transmitted Disease______________________ ___ ___
Heart Murmur___________________________________ ___ ___
Are you under the care of a physician now for any condition? ___ ___
Has there been any recent change in your general health? ___ ___
Have you ever been seriously ill? ___ ___

List medications you are taking.

Medication	For	Medication	For
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___

Please check the appropriate Column	YES	NO
Are you allergic to penicillin, dental anesthetic? or any other drug?	___	___
Have you ever had any problems with prolonged bleeding?	___	___
Have you ever had surgery or radiation therapy?	___	___
Do you have or carry AIDS?	___	___
Have you had a blood transfusion within the past 5 years?	___	___
Have you a history of seizures or convulsions?	___	___
Chest pain or shortness of breath upon mild exertion?	___	___
Do you use tobacco products?	___	___
Do you have any blood disorder, such as anemia?	___	___
Have you had a toothache recently?	___	___
Have you ever had gum surgery?	___	___
Do you have clicking or pain in your jaw joints?	___	___
Do you clinch or grind you teeth?	___	___
Do you have a problem with headaches?	___	___
Do you require antibiotics before treatment by the dentist?	___	___
Do you like the way your teeth look?	___	___
Would you like to have a cosmetic smile analysis?	___	___

In effort to control fees, we recognize that one of the best methods is to control costs. We have therefore instituted the following policies as an aid in minimizing our overhead expenses:

1. If it is necessary to change your appointment time, we request that you notify us at least 24 business hours prior to your appointment. Failure to keep a scheduled appointment without appropriate notification **will** result in a service charge.
2. Payment is due when services are rendered. Returned checks will subject to a $25.00 administration fee **and account balances over 60 days will be subject to finance charges of 1.5% per month.**
3. If you have dental insurance we will be happy to assist you in the processing of your claim. Although we accept assignment on preventive and treatment planned dentistry, we ask that all other visits as well as deductibles and co-payments be taken care of at the time of service. As a courtesy to you we will submit your claim form, but it is your responsibility to provide us with correct and up to date information. When there is a delay in receiving payment from the insurance carrier, it is the responsibility of the insured person to investigate this delay. The responsible party will be requested to make payment in full when an insurance claim is outstanding beyond 45 days from the date of service.

Thank you for your compliance. We look forward to being of service to you.

Wyman B. Martin, D.D.S., and Staff
I agree to the terms listed, and my consent is given for the performance of necessary dental treatment.

Signature of Patient____

THE MARTIN DENTAL CENTER

45 W. Crossville Rd   Suite 505, Roswell, GA 30075

www.themartindentalcenter.com   T – 770-993-7424   F – 678-461-4436

Credit Card Authorization Form

I ____________________________ hereby authorize THE MARTIN DENTAL CENTER to submit claims on my behalf and agree to assign the payment directly to THE MARTIN DENTAL CENTER. I understand that my insurance is an agreement between the insurance company and myself. I further understand that I am responsible for any service fees or balances that may not be covered by my dental benefits plan and any differences resulting from the amount billed and the amount covered by my plan. I authorize the following credit card to be billed for any outstanding balances.

Patient Name: ____________________________

Responsible Party (if different than patient): ____________________________

Please circle credit card: Visa   MasterCard   Amex   Discover   HSA

Phone #:_____________________E-mail address_______________________________

Card #: _________________________________Exp. Date:_______Security Code_____

Street # ____________________________   Zip Code: _______________

Card holder signature: ____

Today's Date: ____________________________

Staff Initials: __________