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: _____

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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

Our goal is to provide quality dental care to all our patients in a timely manner. *Appointments are in high demand,* therefore, we respectfully **request 2 business days notice for cancellations** to allow another patient access to that appointment time. No-shows, late arrivals, and last minute cancellations inconvenience not only the doctor, but our other patients as well. Without a 2 business days notice, you **will incur a fee of $125.** _____ (initial)
If you have any questions regarding the above information, or regarding insurance coverage, please ask us, we are here to help you. Thank you!
I have read and fully understand the office Financial Policy.

x_____ _____
Signature of Patient or Responsible Party Date

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PATIENT PHOTO AUTHORIZATION AND RELEASE

I, _____consent to the taking of photographs (including using digital media) of me, by Javier Martinez D.D.S., M.S. and/or his designee(s), in connection with the evaluation of and possible performance of dental procedures, by Smiles of Orlando, the office of Javier Martinez D.D.S., M.S., and/or his designee(s).

I understand that such photographs, or case histories are needed for my dental record for evaluation and dental documentation.

I understand that in some cases Javier Martinez, D.D.S., M.S., may wish to use such photographs, or case histories of me in print, visual or electronic media (including, but not limited to, dental journals and textbooks, scientific presentations and teaching courses, books, magazines and Internet web sites) for the commercial, non-profit and/or educational purpose of informing the dental profession or the general public about dental treatment methods. In addition, Dr. Martinez may wish to show, and possibly transmit via e-mail, such images to other dentists for consultative purposes.

I understand that neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on my initial consultation with Dr. Martinez.

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").

I understand that the photos, of me are the property of Smiles of Orlando, the office of Javier Martinez D.D.S., M.S., and that upon request with my signature, I may obtain a copy.

Details of photographing have been explained to me in terms I understand.

Dr. Martinez and/or his designee(s) have answered all of my questions to my satisfaction.

Patient Initials _____

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PATIENT PHOTO AUTHORIZATION AND RELEASE

1. *Dental evaluation and documentation* purposes
_____ I agree and authorize _____ I DO NOT agree

2. *Consultative* purposes with other specialists, including transmission and communication via e-mail.
_____ I agree and authorize _____ I DO NOT agree

3. *Teaching purposes*, which include being shown to other patients. *I am aware that my name and identity will not be disclosed.*
_____ I agree and authorize _____ I DO NOT agree

4. *Social Media*, for use and disclosure of my first name, photographic/video images, and/or testimonial for marketing purposes by SMILES OF ORLANDO. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPPA privacy regulations.
_____ I agree and authorize _____ I DO NOT agree

5. *Advertisements* of SMILES OF ORLANDO/ Javier E. Martinez DDS, MS. *I am aware that my name and identity will not be disclosed*
_____ Full Face _____Only mouth_____ I DO NOT authorize the use of these photos for advertising.

6. To place my photos on his professional *web site*. *I am aware that my name and identity will not be disclosed.*
_____Full Face _____Only Mouth_____ I DO NOT authorize the use of these photos for advertising.

I release and discharge SMILES OF ORLANDO, the office of Javier Martinez D.D.S., M.S., and all parties acting under his authority from all rights that I may have in the photographs, or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium. I grant this consent voluntarily, certify that all blanks were filled in prior to my signature and certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Patient/Guardian Date

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntarily.