



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: _____

Medical History

1. What is the estimate of your general health? POOR FAIR GOOD EXCELLENT

2. Have you been hospitalized in the last 2 years? YES NO

Reason: _____

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

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

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

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

5. (Females) Are you currently pregnant? YES NO

6. Do you currently take any medications? If yes, please list:

7. Are you currently taking any blood thinners? YES NO

8. Have you taken any of the following medications? YES 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	Congenital Heart Disease	Radiation /Chemotherapy
Tuberculosis	Heart Surgery	Tumors or growth
Emphysema/ Bronchitis	Pacemaker Kidney Disease	Cancer
Asthma/ Wheezing	Kidney Transplant/Dialysis	Alcohol Use
Persistent Cough	Herpes	Tobacco Use
Pneumatic Fever	Easy Bruising/ Excessive Bleeding	Epilepsy/Seizures/Convulsions
Heart Murmur	Persistent Swollen Glands	Neuralgia
Chest Pain	Blood Transfusion	Paralysis
Heart Attack	Hemophilia	Arthritis/Rheumatism
Shortness of Breathe	Anemia/Sickle Cell	Artificial Joint
Prolapsed Mitral Valve	HIV positive Aids	Muscle Weakness
High Blood Pressure	Diabetes	Hepatitis or Jaundice
Low Blood Pressure	Thyroid Problems	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	Clicking/Popping Jaw	Surgery on Face/Jaw
Bleeding Gums/Periodontal Disease	Difficulty Open/Close Jaw	Sensitive Teeth
Blisters/Ulcers/Cold Sores	Pain in or near ears	Clenching/Grinding Teeth
Swelling/Lumps in Mouth	Sinus Trouble	Loose Teeth
White Coating on Tongue/Throat	Injury on Face/Jaw	

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: _____

Financial Policy

At SMILES OF ORLANDO, our focus is on your oral health—not on insurance contracts. As an out-of-network provider for all PPO plans, we can tailor your treatment plan entirely around your oral health needs, without network restrictions.

How It Works

- **Courtesy Claims Submission** We'll file all of your PPO insurance paperwork on your behalf—no extra charge. Your insurer will reimburse you directly, based on your plan's out-of-network benefits.
- **Fee-for-Service Practice** Because we operate on a fee-for-service basis, payment is due at the time of service. This straightforward approach lets us invest in the highest-quality materials and techniques for your care.
- **Discount Plans Accepted** Members of Careington and AmeriPlan receive reduced fees on eligible services—simply present your membership card at check-in.

Please contact our office to discuss your plan's reimbursement details and explore payment options—our team is here to make everything as easy and transparent as possible.

Payment Options

- **Cash or Check** – accepted at the time of service
- **Credit Cards** – Visa, MasterCard, Discover, American Express (Amex only, 3% fee incurred)
- **CareCredit®** – apply online at carecredit.com or ask us in the office for flexible, interest-free financing. 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, you will be responsible for any collection and/or legal charges up to 35%.

Cancellations and Broken Appointment 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

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

Effective Date: February 16, 2026

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Legal Duties

We are required by law to maintain the privacy of protected health information (PHI); to provide individuals with notice of our legal duties and privacy practices; and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices described in this Notice while it is in effect.

This Notice remains in effect until replaced. We reserve the right to change our privacy practices and the terms of this Notice at any time as permitted by law and to make new provisions effective for all PHI we maintain. If we make significant changes, we will update and post the new Notice prominently in our office and provide copies upon request.

How We May Use and Disclose Health Information

We may use and disclose your health information for treatment, payment, and healthcare operations.

Treatment: We may disclose your health information to specialists or other healthcare providers involved in your care.

Payment: We may use and disclose your health information to obtain reimbursement for services, including billing, claims management, eligibility determinations, and collections. Claims submitted to dental health plans may include relevant health information.

Healthcare Operations: We may use your information for quality assessment, staff training, licensing, credentialing, auditing, and compliance activities.

Individuals Involved in Your Care

We may disclose your health information to family members, friends, or other individuals identified by you who are involved in your care or payment for your care. If a person has legal authority to make healthcare decisions for you, we will treat that person as your personal representative.

Other Permitted and Required Disclosures

We may disclose your PHI as required or permitted by law, including for:

- Disaster relief efforts
- Public health activities (disease prevention, abuse/neglect reporting, product recalls, exposure notifications)
- National security and military activities
- Correctional institutions or law enforcement custody
- Law enforcement purposes or court orders
- Health oversight activities (audits, inspections, investigations)
- Judicial and administrative proceedings
- Workers' compensation programs
- Research approved by an institutional review board
- Coroners, medical examiners, and funeral directors
- Disclosure to the Secretary of the U.S. Department of Health and Human Services for HIPAA compliance investigations
- Fundraising communications (you may opt out of such communications)

Special Protections for Certain Information

Certain records, including HIV-related information, genetic information, mental health records, and substance use disorder treatment records protected under 42 CFR Part 2, may be subject to additional confidentiality protections. If we receive Part 2 Program records, we will use and disclose them only as permitted by your consent or applicable law. Such records will not be used in civil, criminal, administrative, or legislative proceedings against you without proper authorization.

Other Uses Requiring Authorization

Your written authorization is required for disclosure of psychotherapy notes (if applicable), marketing uses of PHI, sale of PHI, or other uses not described in this Notice. You may revoke an authorization in writing at any time, except to the extent we have already relied on it.

Your Health Information Rights

You have the right to:

- Access your records and obtain copies (including electronic copies if maintained electronically). Requests must be made in writing. A reasonable cost-based fee may apply.
- Request amendment of your records in writing. We may deny certain requests but will provide a written explanation.
- Receive an accounting of certain disclosures. Additional requests within a 12-month period may incur a fee.
- Request restrictions on disclosures. We must agree to restrict disclosure to a health plan when services are paid in full out-of-pocket.
- Request confidential communications by alternative means or locations.
- Receive notification of a breach of unsecured PHI.
- Receive a paper copy of this Notice upon request, even if you agreed to receive it electronically.
- Request transfer of your records to another provider.

Complaints

If you have questions or believe your privacy rights have been violated, you may contact our office or file a complaint with the U.S. Department of Health and Human Services. We will provide contact information upon request. We will not retaliate against you for filing a complaint.

Acknowledgement

I acknowledge that I have received a copy of this Notice of Privacy Practices.

Patient Name (Print): _____

Signature: _____

Date: _____

If signed by parent/guardian, Patient Name: _____