Welcome to Michael Ray Martin DDS!

We are delighted you chose us as your Dental and Oral health care provider. The process for booking an initial appointment is simple (whether you found us online or called after a friend referred you).

1. Read and sign the two boxes below; Consent for Services and Appointment Timing and Cancellation Guidelines.
2. Complete the Patient Information Form and Insurance Form if applicable
3. If you have been referred please let us know who referred you so that we can send a Thank You
4. Call us and make an appointment and bring forms with you to your first appointment

Consent for Services

I understand that as a condition for treatment by this office, financial arrangements are made in advance and financial responsibility on the part of each patient is determined **before treatment**. Emergency dental services, or any dental services performed without financial arrangements, will be paid for in cash at the time the services are performed

I understand that if I carry dental insurance all services are charged directly to me and that I am responsible for all charges. The dental office will prepare insurance forms or assist in making collections from insurance companies. These collections will be credited directly to the patient's account, however, the dental office cannot render services with the assumption that charges will be paid by the patient's insurance carrier.

A service charge of 1 ½% per month (18% per annum) will be levied on the unpaid balance for all services exceeding 60 days, unless alternate financial terms are established in writing.

I understand fee estimates for any dental services can only be considered valid for a period of 6 months from the patient examination date.

In consideration for professional services rendered to me, or at my request by the Doctor, I agree to pay therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of the billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at my home or my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content:

Signature of patients or guardian Date Relationship to the Patient

Signature of guarantor of payment/responsible party Date Relationship to Patient

Appointment Timing and Cancellation Guidelines

PLEASE HELP! We ask you to be considerate of others in our family practice; when you arrive late for an appointment all the patients scheduled after you have to wait. Following are the guidelines for our practice:

- **24 hour notice is required for cancellation** (cancellation notice can be delivered in via voice mail 24/7. If you are running late (more than 10 minutes) we may have to reschedule and a fee will be charged
- **A minimum fee of $45 will be incurred for broken appointments** for Hygiene and cleanings and a minimum fee of $55 for Dr. Martin.

_____

Signature/ date

PAYMENT and INSURANCE INFORMATION

Chart #_____Date filed_____Date revised _____

Who will be responsible for payment for services? Patient_____Spouse_____Parent /Guardian_____

(If you are the patient proceed to the next box, if not complete this box)

Gender: M__ F **Married**___**Single**____

Name: _____

Last First MI

Address: _____

Street City State Zip

Phone *(home)*_____*Mobile*_____Best time to call: _____

Employment/Financial Information: *all information is confidential*

Social Security #_____ **Birthdate:** _____

Form of Payment *(circle one)* Credit/debit card Check Other_____

Bank Card; #_____Expiration Date_____Security Code _____

_____ **Occupation**_____**Employer:**_____

_____ Address_____Contact name_____ Phone:_____Cell: _____

Insurance Information

Do you have dental insurance? Yes_____No_____*(if NO stop here, if YES continue)*

Primary

Name of Insured_____Is Insured a Patient?____**Y**___**N**

Last First MI

Relationship to patient: Self____Spouse_____Child_____Other: _____

Insured's Address: _____

Insured's Birthdate: _____

Name of Carrier: _____

ID# _____ Group#_____

Employer: _____ Address: _____

_____

Secondary

Name of Carrier: _____

ID# _____ Group#_____

Insured's Employer:

_____

Address: _____

PATIENT INFORMATION FORM

Chart # _____ Date filed _____ Date revised _____

All information is confidential

OUR PROMISE TO YOU:

As Dental and Oral care professionals, our goal is to provide the highest quality of clinical care possible and ultimately to reinforce our reputation for exceptional customized treatment and superior customer service in the dental community and general population as a whole.

Our Mission is to offer our patients and prospective patients both comprehensive care and education both online and in-person.

Our commitment is to provide comprehensive and innovative treatment while encouraging our patients to seek non-compromising care. In concert with this commitment we promise to educate them concerning the benefits of "appearance-related"dentistry, which can improve their self-image and sense of self-worth.

These forms capture information essential to accomplishing that promise.

How May We Contact You?

Name _____

Last First MI Nickname

Address (permanent) _____

Street City State Zip

EMAIL: _____ **May we send you educational information?**

Yes_ No___

Phone *(home)*_____*(work)*_____Mobile _____

Best time to call:

Tell us about you*:*

Social Security # _____ **Gender** _____ **Family status**

Preferred Appointment times *(circle preferred)* Morning Afternoon Evening Anytime

About your general health:

Date of last dental visit *(including cleanings)* _____

Reason for this visit?

Please check any that apply to you:

_AIDS	_ Fainting	_ Liver Disease	_ Stroke
_ Allergies	_ Glaucoma	_ Mental Disorders	_ Tuberculosis
_Anemia	_ Growths	_ Nervous Disorders	_ Thyroid
_ Arthritis	_ Hay Fever	_ Osteoporosis	_ Tumors
_ Artificial Joints	_ Head Injury	_ Pacemaker	_ Ulcers
_ Asthma	_ Heart Disease	_ Pregnancy	_ Venereal Disease
_ Blood disease	_ Heart Murmur	_ Radiation	_ Codeine Allergy
_ Cancer	_ Hepatitis (A, B, C)	_ Respiratory Problem	_ Penicillin Allergy
_ Diabetes	_ High Blood Pressure	_ Rheumatic Fever	_ OTHER
_ Dizziness	_ HIV	_ Rheumatism	_____
_ Epilepsy	_ Jaundice	_ Sinus Problems	_____
_ Excessive Bleeding	_ Kidney Disease	_ Stomach Problems	

Please List the medications you use: *(over the counter, dietary supplements and medically prescribed)*

*1.*_____ *2.*_____

*3.*_____ *4.*_____

4 More questions about your health: *(use the back if needed)*

1. Have you ever had complications following dental treatment? *If yes, please explain*

   _____

2. Have you been admitted to a hospital or needed emergency care in the past 2 years*? If yes, please explain*

   _____

3. Are you currently under the care of a physician? Yes___No_____*If yes, please explain*

   _____

   Name of physician:

4. Do you have other health conditions that need further clarification? *If yes, please explain*

   _____

Please verify the page 2 & 3: To the best of my knowledge, the preceding information is correct and true. Should any of the preceding information change I will notify Dr. Martin DDS and his office immediately.

_____

Signature of patient or guardian