New Patient Information

THIS PATIENT IS A ○ ADULT ○ CHILD

Dr GREGORY MARTIN DDS, MS

Patient Name | Preferred Name | Ssn # - -

Gender Identity ○ FEMALE ○ MALE ○ TRANSGENDER ○ NONBINARY

Preferred Pronoun ○ SHE ○ HE ○ THEY

Home Address | City | State | Zip

Home Phone | Other Phone | Email

Birthday | Employer / School | Occupation | Referred By

Would you be available on short notice for future appointments or changes? ○ YES ○ NO

We would like to send you a courtesy reminder of your upcoming appointments several days in advance. Please let us know how you would like to receive this reminder.

○ PHONE/VOICEMAIL ○ E-MAIL ○ TEXT MESSAGE

○ PLEASE DO NOT REMIND ME OF UPCOMING APPOINTMENTS

Physician and Emergency

Family Physician | Phone

Emergency Contact | Relationship | Phone

Person Responsible

If different from above, please complete

○ SELF ○ SPOUSE ○ PARENT ○ LEGAL GUARDIAN ○ OTHER

Person Responsible For This Account | Relationship To Patient

Home Address | City | State | Zip

Insurance Info

Please complete the following if you have a current Dental Plan/Insurance.

Subscriber | Relationship | Date Of Birth

Insurance Name | Group # | Subscriber Id

Please let us know if you would like to keep a secondary policy on file in addition to the above primary policy.

Our Policies

Various policies regarding payment & cancellations

Insurance is a contract between you and your insurance company. Gregory Martin DDS, LLC is an out of network provider with all insurance plans. There is no direct relationship between Gregory Martin DDS, LLC and your insurance company. Benefits are determined by the plan selected by you and/or your employer and we are not a party to this contract. The terms of your contract, methods of reimbursement, and determination of your benefits are defined by your insurance company and not Gregory Martin DDS, LLC. We will file your dental insurance claims as a courtesy to you for any primary and secondary PPO coverage plan. Insurance follow-up and/or inquiries are the responsibility of the patient. We do not guarantee payments and are not responsible for providing you with the plan limitations, exclusions, and provisions determined by your insurance company. You agree to pay your portion of the charges not covered by your insurance.

Initials _____

Payment is required at the time of treatment. If utilizing a PPO dental insurance plan, patient agrees to pay the co-payment in full at the time of treatment. Patient understands that they may owe more than the copayment, deductible and/or coinsurance amount collected at each appointment after the insurance claims are settled. Pre-treatment authorizations and estimates from insurance carriers are not a guarantee of payment. Should your carrier not allow assignment to be placed outside the network, the insurance disbursements will come directly to the subscriber and the full amount of your appointments will be collected at the time of treatment. Any amount not paid by the insurance carrier is the sole financial responsibility of the patient. If payment is not made within 30 days of service or receipt of Explanation of Benefits from the insurance carrier, an interest charge of 1.25% per month or 15% per year on unpaid balances will be assessed. Patient understands that a $100 broken appointment fee will be charged for missed appointments or cancellations within 48 hours of the appointment.

Initials _____

Have you been shown a copy of HIPAA?

○ YES ○ NO

Signature ○ PATIENT ○ PARENT ○ GUARDIAN _____ *Date* _____

Dental History

Dr GREGORY MARTIN DDS, MS

1. Do you have a dental problem that you would like to have taken care of as soon as possible? O YES O NO

2. Have you been visiting the dentist regularly prior to visiting our practice? O YES O NO

3. Date of last dental visit: ____/____/____
   Date of last cleaning: ____/____/____

4. When did you last have dental x-rays taken? ____/____/____

5. How often do you brush your teeth? _____

6. How often do you floss your teeth? _____

7. Do your gums bleed when you brush or floss your teeth? O YES O NO

8. Do you feel any pain in your teeth? O YES O NO

9. Do you think you have bad breath at times? O YES O NO

10. Have you ever had an injury to your mouth or jaw? O YES O NO

11. Do you have any pain in your jaw joints? O YES O NO

12. Do you suffer from migraine headaches? O YES O NO

13. Have you had your wisdom teeth extracted? O YES O NO

14. Have you ever received a dental implant? O YES O NO If so please provide the approximate date(s): ____/____/____

15. Do you grind or clench your teeth during the daytime or at night? O YES O NO

16. Do you smoke or use any other form of tobacco? O YES O NO

17. Have you noticed any lumps, growths, or sore spots in your mouth? O YES O NO

18 Have you ever had periodontal treatment or been referred to a periodontist? O YES O NO

19. Have you had any previous problems with dental treatment? O YES O NO

20 Are you happy with the appearance of your teeth? O YES O NO

21. Are you nervous about coming to the dentist or undergoing dental treatment? O YES O NO

22. Do you experience frequent dry mouth? O YES O NO

23. Do you snore? O YES O NO

24. Do you use a C-PAP machine? O YES O NO

25. Are you interested in orthodontic clear aligner therapy to straighten your teeth? O YES O NO

26. Are you interested in any of the following cosmetic treatments in our office?
   O Tooth Whitening O Cosmetic Botox O RF Microneedling O Tattoo Removal
   O Cosmetic Filler (Juvéderm, etc.) O LaseMD Ultra Laser treatment

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Dr GREGORY MARTIN DDS, MS

Medical History

1. Are you in good health? O YES O NO

2. Have you had any significant changes to your health or weight in the last year? O YES O NO

3. Are you currently being treated for any medical condition or have you been in the last year? O YES O NO

4. Do you have a primary care physician? If so then who _____

5. When was your last physical examination by your primary care physician? _____

6. Have you ever been hospitalized for an illness or any other medical condition? O YES O NO

7. Please list any medications, non-prescription drugs, or herbal supplements that you currently take (including PrEP):

_____

8. Do you have any allergies to medication, latex/rubber, or anything else? If yes please list:

_____

9. Do you experience any difficulty walking or exercising or experience shortness of breath? O YES O NO

10. Please list and provide the date of any surgery that you have ever had: _____

11. Have you ever been instructed to take an antibiotic premedication prior to dental treatment or a dental cleaning? O YES O NO

12. Do you have any artificial joints or heart valves? O YES O NO

13. What is your current HIV status: O POSITIVE O NEGATIVE O POSITIVE/UNDETECTABLE O UNKOWN

14. Do you experience prolonged bleeding, have a bleeding disorder, or are taking blood thinners? O YES O NO

15. Please check any of the following conditions that you have ever had or currently have:

- O Chest pain, angina
- O Heart attack
- O Stroke
- O Rheumatic fever
- O Mitral valve prolapse
- O Heart problems, murmur
- O Asthma or Emphysema
- O Pacemaker
- O Lung disease
- O Tuberculosis
- O Leukemia
- O Osteoporosis medication
- O Psychiatric disorder / treatment
- O Circulatory problems
- O Blood transfusions
- O Eating disorder
- O Fainting / Dizzy spells
- O Low blood pressure
- O Hyper / Hypoglycemia
- O Mental or Nervous disorder
- O Other communicable disease / Transmissible infection
- O Cancer
- O Steroid therapy
- O Diabetes (O Type I) (O Type II)
- O Stomach ulcers
- O Seizures / Epilepsy
- O Arthritis / Rheumatism
- O High blood pressure
- O Kidney disease
- O Thyroid disease
- O Drug / Alcohol dependency
- O Autoimmune Disorder

16. Please list any other condition that you have had not listed above: _____

17. Are you currently pregnant or breastfeeding? O YES O NO If pregnant, expected delivery date: ____/____/____

18. Have you developed a fever or chills in the last 24 hours? O YES O NO

19. Have you noticed a new rash, lesion, or outbreak anywhere on your skin? O YES O NO

20. Are your immunizations up to date? O YES O NO

21. Have you ever taken any oral or IV bisphosphonates (i.e. Fosomax, Reclast, Zoledronic acid, etc)? O YES O NO

22. Which medications do you normally take to manage pain? (i.e. Tylenol, Advil, etc): _____

23. Have you ever been treated with radiation therapy to your head, neck, or jaw? O YES O NO

24. Have you ever undergone chemotherapy? O YES O NO

25. Is there any additional information pertaining to your overall health or dental history that has not been addressed above? O YES O NO

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