Your Smile Designer

DR. ROBERT MARTINICH, DMD, PC 303-791-0160

PERSONAL INFORMATION

FULL NAME: ______________________________ **DATE OF BIRTH:** ________________

PREFERRED NAME: __________________________ **SEX** ☐ **MALE** ☐ **FEMALE**

EMAIL: __________________________________ **CELL NUMBER:** _________________

HOME PHONE NUMBER:_____________________ **WORK NUMBER:**_________________

ADDRESS: ____

SOC SEC #:______________________________ **EMPLOYER:**____________________

DENTAL INSURANCE INFORMATION

NAME OF INSURED, IF OTHER THAN PATIENT:__________________________________

DATE OF BIRTH: ____________________________**SOC SEC #:** __________________

RELATIONSHIP TO INSURED:___________________ **CELL NUMBER:**________________

INSURANCE CO:_____________________________ **PHONE NUMBER:**_______________

INSURED ID #______________________________ **INSURED GROUP #**______________

EMPLOYER OF INSURED:______________________

WHOM MAY WE THANK FOR REFERRING YOU? ____________________________________

HIPPA COMPLIANCE CONSENT FORM

- You have the right to restrict how your protected health information is used and disclosed for treatment, payment or health care operations.
- By signing this form, you consent to our use and disclosure of your protected healthcare information for treatment, payment or operations.

Family Members Allowed and Members Date of Birth:

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Signature:____ Date:_______________

Witness____ Date:_______________

PATIENT HEALTH INFORMATION

MEDICAL HISTORY

Current Medications or drugs: ☐ YES ☐NO IF YES, PLEASE LIST:

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Recent Hospitalizations or Surgeries: ☐ YES ☐NO IF YES, PLEASE LIST: ______________________________

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Any Allergies, Including LATEX: ☐ YES ☐NO IF YES, PLEASE LIST: ___________________________________

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Any Allergies or Problems with anesthetics: ☐ YES ☐NO IF YES, PLEASE LIST: __________________________

WOMEN, IF PREGNANT ☐ YES ☐NO IF YES, PLEASE LIST DUE DATE: _______________________________

Do you have, or had, any of the following? Indicate YES with a check.

☐ Circulatory Problems	☐ Nervous problems	☐ Radiation	☐ STD /Herpes
☐ ANY heart problems	☐ Measles	☐ Diabetes	☐ Hepatitis
☐Prosthetic valves	☐ Mumps	☐ Arthritis	☐ HIV/ AIDS
☐ Mitral valve prolapse	☐ Anemia or blood problems	☐ Malignancies	☐ Asthma
☐ Scarlet fever	☐ Typhoid fever	☐ Epilepsy / Seizures	☐ Tuberculosis
☐ Stroke	☐ Psychiatric care	☐Excessive bleeding	☐ Sinus Problems
☐ Rheumatic fever	☐ Recreational drugs	☐Prosthetic joints	☐ Liver problems
☐ Kidney problems	☐ Eye disorders	☐ Ulcers	☐ Cancer
☐ Abnormal blood pressure	☐Bleeding gums	☐ Painful jaw	☐ OTHER

PLEASE LIST ANY MEDICAL CONDITIONS NOT MENTIONED: ______________

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The above information is accurate and complete to the best of my knowledge.

I hereby consent to necessary treatment, including the use of anesthetics or x-rays.

SIGNED: DATE:

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APPOINTMENT POLICY

- Your time is valuable! You want us to be on time!
- Keeping your oral cleaning appointments is important for your health.
- We will try to schedule appointments at your preference for day and time.
- Please notify us 48 hours in advance to change your appointment.
- We accept text messages, emails and voice messages for appointment changes.
- Emergencies happen, please be respectful of our schedule and notify us.
- Missed appointments may be assessed $100 fee.
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FINANCIAL POLICY

- Payment in full is expected when services are rendered.
- Insured Patients will pay the estimated patient co-pay portion at time of service.
- Pre-Authorization on treatment, available upon request.
- Billing insurance is done electronically and daily as a courtesy.
- We accept Mastercard, Visa, Discover, American Express and CARECREDIT.
- $25.00 charge for returned checks.

Signature: **Date:**

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