MARTIN ENDODONTICS
Clark A. Martin, D.M.D. • Alexa C. Martin, D.M.D.
Diplomates of the American Board of Endodontists
435 N. Bedford Dr., Ste. 215
Beverly Hills, CA 90210
(310) 278-5403

PATIENT INFORMATION

Full Name: _____ Preferred Name: _____
Primary Phone # (Home/Business/Cell): _____ Secondary Phone: _____
Gender: _____ Birthdate: _____ Marital Status: M_____S_____D_____W_____DP_____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Soc. Sec. #: _____ Driver's License #: _____
Email Address: _____
CONSENT TO COMMUNICATE ELECTRONICALLY VIA TEXT/EMAIL PERTAINING TO APPOINTMENTS, TREATMENT, AND SCHEDULING: Yes ☐ No ☐
Employer: _____ Business Address:_____
City: _____ State: _____ Zip Code: _____
Whom may we thank for referring you? _____
Emergency Contact Name: _____ Relation to you: _____
Emergency Contact Phone Number: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____
Relationship: _____ Birthdate: _____ Soc. Sec. #: _____
Employer: _____ Business Phone Number: _____
Dental Insurance Company Name: _____ Group #: _____
Dental Insurance Company Address: _____

DENTAL HISTORY

Reason for today's visit _____
Are you having pain or discomfort at this time? Yes ☐ No ☐
Have you ever had root canal therapy (endodontic treatment?) Yes ☐ No ☐
Have you ever had a bad experience in a dental office before? Yes ☐ No ☐
Do you feel **VERY** nervous about having dental treatment? Yes ☐ No ☐
Are you interested in dental sedation if treatment is needed (nitrous, oral sedation, IV sedation)? Yes ☐ No ☐

For Office Use Only

Review Date: _____ Int. _____
Review Date: _____ Int. _____
Temp _____ BP _____

MEDICAL HISTORY

Primary Physician: _____ Tel: _____ Date of last exam: _____

Have you been hospitalized in the last 5 years? _____ Describe: _____

Are you pregnant or nursing? _____ Are you taking oral contraceptives? _____

Are you taking any prescription or over the counter medications (including ibuprofen, diet supplements, etc.)?

Yes ☐ No ☐ Please list each one: _____

_____

Are you currently taking or do you have any history of taking bisphosphonates (bone density meds such as Fosamax, Reclast, etc.): Yes ☐ No ☐

PLEASE CHECK ALL THAT APPLY

☐ Clenching	☐ Difficulty Breathing	☐ Renal Dialysis
☐ TMJ Disorder	☐ Endocarditis	☐ Asthma/Emphysema
☐ Gum (Periodontal) Surgery	☐ Heart Attack Date_____	☐ Pneumonia
☐ Jaw Surgery	☐ Heart Murmur	☐ Tuberculosis
☐ Orthodontics	☐ Irregular Heart Beat	☐ Total Joint Replacement
☐ Arthritis	☐ Rheumatic Fever	☐ Adrenal Disease
☐ Back Injury	☐ Scarlet Fever	☐ HIV/AIDS
☐ Neck Injury	☐ Stroke Date_____	☐ Anemia
☐ Migraines	☐ High Blood Pressure	☐ Bruising
☐ Epilepsy	☐ Chronic Sinusitis	☐ Cancer
☐ Seizures	☐ Problems Swallowing	☐ Chemotherapy
☐ Fainting	☐ Eye Disease	☐ Radiation to Head/Neck
☐ Numbness	☐ Trauma	☐ Anxiety
☐ Angina/Chest Pain	☐ Hyperthyroidism	☐ Depression
☐ Artificial Valves	☐ Hypothyroidism	☐ Psychiatric Care
☐ Mitral Valve Prolapse	☐ Hepatitis Type _____	☐ Diabetes Type_____
☐ Cardiac Surgery	☐ Liver Disease	☐ Herpes/Cold Sores
☐ Congenital Heart Defect	☐ Organ Transplant	☐ Canker Sores

Please list any significant medical condition(s) or surgeries you have had (not listed above): _____

_____

Do you premedicate with antibiotics for any heart or other condition before dental treatment? Yes ☐ No ☐

Please specify any ALLERGIES OR ADVERSE REACTIONS you have ever had to local anesthetics, penicillin, latex, antibiotics, aspirin, or any other medications: _____

Have you received the COVID-19 vaccine? Yes ☐ No ☐ Any current symptoms? _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. If I ever have a change in my health or medications, I will inform this office at the next appointment without fail. I authorize and request my insurance company to pay directly to the dentist or the dental group insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all submissions. I understand payment is due in full at the time of treatment. I understand a minimum $90.00 for a broken appointment without 24 hours notice or legitimate cause will be my responsibility.

Signature of patient/parent_____ **Date**_____

MARTIN ENDODONTICS
CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____
Address:_____
Telephone:_____
Social Security Number: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Clark A. Martin, D.M.D.
Telephone: (310) 278-5403
E-Mail: drmartinendo@gmail.com
Address: 435 N Bedford Drive, Suite 215, Beverly Hills, CA 90210

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____ have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's
Name:_____ Relationship to Patient _____

YOU ARE ENTITLED TO A COPY OF THE CONSENT AFTER YOU SIGN IT

REVOCATION OF CONSENT

I revoke my Consent for use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.