MARTIN ENDODONTICS
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435 N. Bedford Dr., Ste. 215
Beverly Hills, CA 90210
(310) 278-5403

PATIENT INFORMATION

Date_____

Primary Phone # Home/Business/Cell_____ Secondary Phone #_____

Name_____Soc. Sec.#_____

Address_____City_____

State_____ Zip_____ Drivers License#_____

Patient Email Address:_____

Sex: M_____F_____ Birthdate: _____ Marital Status: M_____S_____D_____W_____DP_____

Employer_____Occupation_____

Business Address_____City_____Zip_____Phone #_____

Spouse/Domestic Partner/Parents Name_____Phone #_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____Phone #_____

RESPONSIBLE PARTY

Who is legally responsible, if other than patient?_____Relationship_____
Address_____City_____State_____Zip_____
Drivers License#_____Birthdate_____Phone #_____

DENTAL INSURANCE INFORMATION

Name of insured_____Relationship_____

Birthdate_____Soc. Sec.#_____Date Employed_____

Employer_____Business Phone_____

Business Address_____City_____State_____Zip_____

Insurance Company_____Group #_____

Address_____City_____State_____Zip_____

DENTAL HISTORY

Reason for today's visit_____
Are you having pain or discomfort at this time? Y___N___ Have you ever had root canal therapy (endodontic treatment)? Y___N__
General Dentist_____Phone_____

Review Date: _____ Int. _____

Review Date: _____ Int. _____

Temp _____BP _____Date_____

COVID Screening _____

OFFICE USE ONLY

MEDICAL HISTORY

Primary Physician_____Tel:_____Date of last exam_____
Have you ever had any serious illnesses/operations?_____Describe_____
Have you been hospitalized in the last 5 years?_____Describe_____
(Women)Are you pregnant?_____Due Date_____Nursing?_____Are you taking oral contraceptives?_____

Check **Yes** or **No** of the following which you had or have at the present

DENTAL	**CARDIOVASCULAR**	**HEAD/NECK**	**HEMA/IMMUNE**
Y N	**Y N**	**Y N**	**Y N**
☐☐Blisters	☐☐Angina/Chest pain	☐☐Chronic Sinusitis	☐☐Adrenal
☐☐Chronic pain	☐☐Artificial Valves	☐☐Problems swallowing	☐☐AIDS/HIV
☐☐Clenching	☐☐Cardiac Surgery	☐☐Eye Disease	☐☐Anemia
☐☐TMJ	☐☐Circulatory Problems	☐☐Trauma	☐☐Transfusions
☐☐Gum Surgery	☐☐Difficulty breathing	☐☐Thyroid Disease	☐☐Bruising
☐☐Orthodontics	☐☐Endocarditis	**OTHER**	☐☐Cancer
NEUROMUSC	☐☐Heart Attack	☐☐Hepatitis A B C	☐☐Chemotherapy
☐☐Arthritis	☐☐Heart Murmur	☐☐Liver Disease	☐☐Radiation
☐☐Back Injury	☐☐Irregular Heart Beat	☐☐Organ Transplant	☐☐Psychiatric Care
☐☐Epilepsy	☐☐Mitral Valve Prolapse	☐☐Renal Dialysis	☐☐Diabetes
☐☐Seizures	☐☐Pacemaker	**RESPIRATORY**	☐☐Venereal Disease
☐☐Fainting Spells	☐☐Rheumatic fever	☐☐Asthma/Emphysema	**SUPPLEMENTAL**
☐☐Numbness	☐☐Scarlet fever	☐☐Pneumonia	☐☐Bisphosphonates
	☐☐Stroke	☐☐Tuberculosis	
	☐☐High Blood Pressure		

If you have a current medical problem or another condition not listed here, describe_____
_____
Have you ever been advised to take an antibiotic premedication before your appointment?_____
Are you sensitive or allergic to any medication such as:

Y N	**Y N**	**Y N**	**Y N**	**Y N**	**Y N**
☐☐Penicillin	☐☐Erythromycin	☐☐Clindamycin	☐☐Codeine	☐☐Aspirin	☐☐Latex

☐☐Anesthetics **Other**_____

Do you currently use any recreational drugs? ☐**Y**☐**N**

List of medications you are currently taking: Purpose of medications:

_____ _____
_____ _____
_____ _____

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: dr.clarkmartin@yahoo.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 you 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.