PATIENT INFORMATION

NAME_____

ADDRESS_____

_____

PHONE NUMBER_____CELL_____

EMERGENCY NUMBER_____

SS#_____

BIRTHDATE_____

AGE_____ HEIGHT_____WEIGHT_____

EMAIL_____

REFERRED BY_____

DENTIST_____

PHYSICIAN_____

INSURANCE INFORMATION

DENTAL INSURANCE_____

MEDICAL INSURANCE_____

SUBSCRIBER'S NAME_____

SUBSCRIBER'S BIRTHDATE_____

SUBSCRIBER SS#OR ID#

DENTAL_____MEDICAL_____

HEALTH HISTORY

ARE YOU UNDER A PHYSICIAN'S CARE_____

IF YES WHY?_____

_____

PHYSICIAN'S NAME AND PHONE NUMBER_____

_____

ALLERGIES

_____

_____

PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS

_____

_____

_____

HEIGHT_____WEIGHT_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING only circle the yes ones

RHEUMATIC FEVER	Y	LIVER DISEASE	Y	*I HEREBY CERTIFY THAT THE*
HEART DISEASE	Y	CONVULSIONS, SEIZURES	Y	INFORMATION CONTAINED ON
MITRAL VALVE PROLAPSE	Y	GLAUCOMA	Y	THIS PAGE IS TRUE AND CORRECT
HIGH BLOOD PRESSURE	Y	IMMUNO SUPPRESION	Y	*SIGN ON NEXT LINE*
DIABETES	Y	SUBSTANCE ABUSE /SUBOXONE	Y Y	X
BLOOD DISEASE	Y	THYROID DISEASE	Y	DOCTOR ONLY
TUBERCULOSIS	Y	PROLONGED BLEEDING	Y	I HAVE READ THE MEDICAL HISTORY
ASTHM A	Y	DIFFICULTY WITH DENTAL EXTRACTIONS	Y	AND CONFIRM THAT IT ADEQUATELY
BRONCHITIS	Y	ARTIFICIAL HEART VALVE	Y	STATES PAST AND PRESENT
RADIATION THERAPY	Y	JOINT REPLACEMENTS	Y	CONDITIONS
CHEMOTHERAPY	Y	WOMEN ONLY		DATE
KIDNEY DISEASE	Y	ARE YOU TAKING BIRTH CONTROL	Y	SIGN
HEPATITIS	Y	ARE YOU PREGNANT	Y	DATE
STOMACH ULCERS	Y	DATE OF LAST MENSTRUAL CYCLE		SIGN

Christopher H. Martone, D.M.D., P.C.

Patient Consent for Use of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.
The policy is located under the television on the wall.

By signing this form, you are consenting to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing; however, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Patient signature_____

Relationship to Patient (if other than patient):_____

Date_____

Witness_____

I authorize the release of any dental or medical information necessary to process my claim and request payment of benefits directly to Dr. Martone for services provided. I understand that I am fully responsible for any portion of these services that are not covered by my insurance benefits.

SIGN HERE_____**DATE**_____

PLEASE BE AWARE THAT THE HEALTH PROVIDER IS NOT RESPONSIBLE FOR OBTAINING PAYMENT FROM THE INSURANCE COMPANY. ALTHOUGH THE HEALTH PROVIDER WILL FILE A CLAIM AS A COURTESY TO THE PATIENT, OBTAINING PAYMENT FROM THE INSURANCE COMPANY IS ACTUALLY A MATTER BETWEEN THE PATIENT AND THE INSURANCE COMPANY AND THE RESPONSIBILITY OF THE PATIENT.