

DWAYNE KIM MARTIN, D.D.S., M.S.

PERIODONTICS AND DENTAL IMPLANTS

HILLTOP PROFESSIONAL BUILDING
1855 SAN MIGUEL DRIVE, SUITE 21
WALNUT CREEK, CALIFORNIA 94596
(925) 932-1422 • FAX (925) 932-2020
Email: martinperio@sbcglobal.net
www.martinperiodontics.com

_____YOUR FIRST APPOINTMENT IS ON_____AT_____.

We are pleased to welcome you as a new patient to our office.

On your first visit we will carefully examine your mouth and make a diagnosis. Appropriate x-rays are necessary if we are to be accurate in our evaluation. We will check with your dentist and see that the x-rays and/or digital radiographs can be emailed to us.

After examination we will outline our treatment plan and tell you the cost of our treatments. This is a good time to ask questions and feel certain we will answer them as completely as possible.

Enclosed with this letter are some medical-dental history forms. We would appreciate your filling them out carefully and bringing them with you on this first appointment. Should you find it necessary to cancel an appointment, a 48 hour notice is requested. We recognize that your time is valuable and we will make every effort to see you at your appointed time.

AREA DIRECTIONS

From Danville and South—Take 680 north towards Walnut Creek. Take the Rudgear exit. Continue straight, and you will be on North Broadway. At the first stoplight turn right on Newell Ave. Continue on Newell 400 yards until reaching the crest of hill and turn left onto San Miguel Dr. The office is the second building on the left “Hilltop Professional Building”.

From Concord via Ygnacio Valley Road—Turn left off Ygnacio Valley Road at North Broadway in Walnut Creek. Continue on Broadway to Mount Diablo Blvd. Make a left and immediately get in the right lane. Take the first right (after passing Safeway) onto San Miguel Dr. Travel approximately 1/4 mile—the office will be on the right.

From Concord, Martinez Hwy. 24—Go through the 680-24 interchange, taking 680 South towards San Jose. Stay in the right lane and exit at South Main. Stay in the left lane and turn left onto South Main. Pass under the freeway, and at Kaiser Hospital, turn right onto Newell Avenue. Continue on Newell until reaching the crest of hill, and turn left onto San Miguel Dr. The office is the second building on the left.

From Oakland, Orinda via Hwy. 24—Take the San Jose turnoff Hwy. 680 Mt. Diablo Blvd and stay in the left lane. Take this off-ramp and go straight on Mt. Diablo Blvd. Continue on Mt. Diablo Blvd. and turn right (after passing Safeway) onto San Miguel Dr. Travel approximately 1/4 mile and the office will be on the right “Hilltop Professional Building”.

DWAYNE KIM MARTIN, D.D.S., M.S.
PERIODONTICS AND DENTAL IMPLANTS

Name: _____ Date of Birth: _____

What name do you want us to call you? _____ (circle) Male / Female

Home Address: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell# _____

Best daytime phone number: _____ **Email address:** _____

In Case of Emergency: _____ Contact# _____

Employer: _____

Business Address: _____

Social Security #: _____

Who do we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co.: _____

Name of Insured Person: _____ Relationship to Patient: _____

Birth Date of Insured: _____ Social Security or ID#: _____

Group#: _____ Group Name/Employer: _____

Do you have additional dental insurance? (circle) Yes / No If yes, please complete the following:

Secondary Insurance Co.: _____

Name of Insured Person: _____ Relationship to Patient: _____

Birth Date of Insured: _____ Social Security or ID#: _____

Group#: _____ Group Name/Employer: _____

**To the best of my knowledge, I have answered every question completely and accurately.
I will inform my dentist of any change in my health and/or medication.**

Patient/Guardian Signature

Today's Date

Health History

Name of Physician: _____ Phone# _____

Name of Dentist: _____ Phone# _____

circle

1. Have you been to a hospital during the past 2 years? yes no
2. Have you been under the care of a physician during the past 2 years?..... yes no
3. Are you currently taking any medications? yes no
If yes, please list or use a 2nd page _____
4. Have you taken any medications or drugs during the past year? yes no
If yes, please list _____
5. Are you allergic or sensitive to any drug? yes no
If yes, please list _____
6. Are you allergic or sensitive to latex? yes no
7. Are you allergic or have reactions to anesthetics? yes no
8. Have you ever had a history of excessive bleeding? yes no
9. Have you had any of the following?

	Yes	No		Yes	No		Yes	No
Heart Trouble	___	___	Rheumatic Fever	___	___	Liver Disease	___	___
Mitral Valve Prolapse	___	___	High blood Pressure	___	___	Cancer	___	___
Valve Replacement	___	___	Anemia	___	___	Stroke	___	___
Irregular Heartbeat	___	___	Thyroid Disease	___	___	Epilepsy	___	___
Pacemaker	___	___	Diabetes	___	___	Seizure	___	___
Angina	___	___	Asthma	___	___	Kidney Trouble	___	___
Heart Attack	___	___	Bronchitis	___	___	Artificial Joint	___	___
Bypass Surgery	___	___	Emphysema	___	___	Sinus Trouble	___	___
Hepatitis	___	___	Tuberculosis	___	___	Cortisone Medicine	___	___
Jaundice	___	___	Psychiatric Treatment	___	___	(Steroids, Prednisone)	___	___
Other _____								

10. To your knowledge, have you ever been exposed to, or tested positive for HIV (AIDS virus)?..... yes no
11. Have you had surgery in the past 5 years? yes no
12. Do you smoke? If yes, how many packs a day? yes no
13. (Women) Are you pregnant? yes no
Do you take birth control pills? yes no

If yes, please be advised that antibiotics, which may be given to you for oral surgery, may render your birth control pills ineffective. Therefore, another form of birth control must be used for the remainder of the menstrual cycle during which you take an antibiotic.

14. Are you or have you taken any bisphosphonates ie: Fosamax, Bonivia etc... for Osteopenia or Osteoporosis? yes no
15. Have you ever taken prescription medication for weight reduction (diet pills)? yes no
If yes, did you take any of the drugs listed below? (Indicate with an X on the line)

___ Fen-Phen (fenfluramine+Phentermine) ___ Pondimin (fenfluramine) ___ Redux (dexfenfluramine)

If you have ever taken any of the above drugs, have you had medical exam to insure that your heart valves were not affected? yes no

Have you ever been under the care of a physician for any major illness or injury other than those noted above? If so please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication(s).

Patient Signature _____ **Date** _____

Review by Dr. _____ **Date** _____

NAME: _____

DATE: _____

DENTAL QUESTIONNAIRE

1. Are you experiencing pain in your mouth at this time? **Yes / No**

Where? _____ Lately? _____

2. Have you had swollen or bleeding areas of the gums? **Yes / No**

3. Have you in the past ever had periodontal (gum) treatment? **Yes / No**

4. If so, when and what type? _____

5. Are your teeth sensitive to hot, cold or sweets? **Yes / No**

6. Have the teeth separated, creating spaces between them in recent years?
Yes / No

7. Are you satisfied with the appearance of your teeth? **Yes / No**

8. Are you aware of clenching, gritting or grinding your teeth? **Yes / No**

9. What oral hygiene aids do you use (toothbrush, floss, etc...)

10. Are you fearful of dental treatment? **Yes / No**

11. Are you interested in sedation? **Yes / No**

12. Do you take antibiotics for dental treatment? **Yes / No**

12. How often do you have your teeth professionally cleaned? _____

Office Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with at least 48 hours' notice. This courtesy on your part will make it possible to give your appointment to another patient who needs our care. We are aware that unforeseen events sometimes require missing an appointment. After missing your second appointment without notifying us 48 hours in advance, we reserve the right to charge a broken appointment fee.

Please schedule only definite appointments.

I certify that I have read and been fully informed of the office cancellation policy.

Patient Signature

Date

Financial Policy

No insurance: A treatment plan will be presented to you and payment is due at time of service. In special situations, other arrangements are possible, and the staff will assist you in this regard.

For those with insurance: Not all services are covered by insurance. In the event your insurance plan determines a service(s) to not be covered, you will be responsible for the complete charge. Our staff **cannot guarantee** your eligibility and coverage. Insurance rules and limits vary with insurance plans. If your insurance plan denies a service, you will be responsible for the charge. As per patients request the office can send a pre-determination to your dental plan to determine estimated dental payment and patient co-pays.

We offer **Care Credit** payment plan as well.

The doctor make their recommendations based on their knowledge of what is best for your oral health, not on what your benefits will cover.

I certify that I have read and been fully informed of the office Financial Policy.

Signature of Patient or Responsible Party: _____ **Date:** _____

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
*HIPAA***

I have received (or have been offered) a copy of this office's Notice of Privacy Practices.
By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

Signature: _____

Patient Name: _____

Patient Representative (if minor): _____

Date: _____

Witness: _____

please let us you if you like a copy of the "Notice of Privacy Policy"

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgements
- An emergency situation prevented us from obtaining acknowledgments
- Other (please specify): _____