Bruce Martinson Family & Cosmetic Dentistry
317 E Wayzata Boulevard, Wayzata, MN 55391
(952) 473-4639
martinsondental.com/

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Patient's signature: Date:

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PRIVACY POLICY CONSENT

I understand that as part of my dental care, Bruce Martinson, DDS Family & Cosmetic Dentistry creates and maintains health records that describe my health history, dental information, symptoms, examinations, test results, diagnosis, procedures, treatment, & plans for future care of treatment I may receive. I understand that health information collected and stored will be used for the following:

To support my care and treatment at Bruce Martinson, DDS Family & Cosmetic Dentistry (treatment)

For continued treatment among health professionals who are involved and contribute to my health care (treatment)

For billing purposes including information regarding my diagnosis, treatment, and services rendered (payment)

For insurance claim processing by a third-party payer for verification of services billed (payment)

A tool for routine healthcare operations such as assessing quality improvement (healthcare operations)

I understand the Notice of privacy Practices from Bruce Martinson, DDS, Family & Cosmetic Dentistry defines more information regarding the use and disclosure of my protected health information as well as my rights to my health information.

By signing this, I acknowledge that Bruce Martinson DDS Family & Cosmetic Dentistry has offered me a copy of their Notice of Privacy Practices. I acknowledge and understand the rights that I have over my protected health information. I authorize the use and disclosure of my protected health information as specified in the Notice of Privacy Practices. I authorize the use and disclosure for treatment, payment, and healthcare operations purposes for Bruce Martinson, DDS Family & Cosmetic Dentistry.

This consent will continue forever unless I cancel it by writing to Bruce Martinson, DDS Family & Cosmetic Dentistry, 317 East Wayzata Blvd, Wayzata, MN 55391. If the consent is canceled, it will not change releases that have already been made prior to the date of cancelation.

Patient's signature: Date:

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FINANCIAL POLICY

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Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be considered delinquent. If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours (two business days) in advance, you will be charged $50. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Bruce Martinson Family & Cosmetic Dentistry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Bruce Martinson Family & Cosmetic Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Bruce Martinson Family & Cosmetic Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Bruce Martinson Family & Cosmetic Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Bruce Martinson Family & Cosmetic Dentistry.

Patient's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Bruce Martinson Family & Cosmetic Dentistry, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Bruce Martinson Family & Cosmetic Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Bruce Martinson Family & Cosmetic Dentistry cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Bruce Martinson Family & Cosmetic Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Bruce Martinson Family & Cosmetic Dentistry.

Patient's signature: Date: