GREENFIELD FAMILY DENTISTRY, P. C.
DANIEL MASTERS, DMD

Patient Information

Patient Name: ______________________________ Date: ____________
Last First MI

Preferred Name: ____________ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________ Birth Date: ____________

Phone (Home): ____________ (Work): ____________ Ext: ____ Cell Phone: ____________

E-mail Address: ____________

Address: ______________________________
Street Apartment #
____
City State Zip Code

Patient's or Parent's Employer ____________ Work Phone ____________

Spouse or Parent's Name ____________ Employer ____________ Work Phone ____________

If Patient is a college student, name of school/college ____________ City ____________ State ____________

Person to contact in case of emergency ____________ Relationship ____________ Phone ____________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________ Birth Date: ____________

Phone (Home): ____________ (Work): ____________ Ext: ____

Address: ______________________________
Street Apartment #
____
City State

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ____________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____________

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ____________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____________

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ____________

Name of person or office referring you to our practice: ____________

Name: **Health Information**

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain (angina)
- ☐ Convulsions
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack/Failure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral valve prolapse
- ☐ Nervous Disorders
- ☐ Persistent Cough
- ☐ Radiation Treatment
- ☐ Recent weight loss, fever, night sweats
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Shortness of breath
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Ankles/Limbs
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Venereal Disease
- ☐ Ulcers

OTHER:
- ☐ ________________
- ☐ ________________

FOR WOMEN ONLY:
Is there any possibility of pregnancy? ☐ Yes ☐ No If yes, what month? ______ Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

- Do you have allergies to any of the following: (Circle please)

Codeine Penicillin Latex Nickel Sulfa Other: ________________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- Name of Physician: ____________________________________ Phone:__________
- Please list all medications that you are currently taking, including over the counter and vitamin supplements ____
  ____
  ____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____

Dental History

Date of Last Dental Visit: ________________

	Yes	No
• Do you use tobacco products?	☐	☐
• Do your gums bleed while brushing or flossing?	☐	☐
• Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
• Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
• Do you feel any pain to any of your teeth?	☐	☐
• Do you have any sores/lumps in or near your mouth?	☐	☐
• Do you have frequent headaches?	☐	☐
• Do you clench or grind your teeth?	☐	☐

- Have you ever experienced any of the following in your jaw joint? (circle please)
  Clicking Difficulty in opening/closing
  Pain (ear, side of face, joint) Difficulty in chewing

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Consent for Services

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If ever I have any change in my health, I will inform the doctor at the next appointment without fail.

I hereby give my permission to be tested for blood borne disease should there be an accidental exposure to a member of our health team.

The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _________________,I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time services are rendered unless other arrangements have been made. I authorize payment to Greenfield Family Dentistry, P.C. of the dental benefits otherwise payable to me. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I ___________________________ grant my permission to you or your assignee, to telephone me at home or at my work
Please Print Name
to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____________________________________ Date: _____________Relationship to Patient: ____________
Signature of patient, parent or guardian

____
PRINT Name of guarantor of payment/responsible party

_____________________________________ Date: ____________ Relationship to Patient: ____________
Signature of guarantor of payment/responsible party

Greenfield Family Dentistry

As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to dental treatment, and we will do so without charge.

However, in order to avoid misunderstandings, please read carefully and understand the following policies in regard to dental insurance benefits.

- Our professional treatment is rendered to you, not the insurance company. You are responsible to us for the obligation of payment for treatment.
- To serve and assist you in utilizing your dental insurance, this office accepts assignment of your benefits. It is your responsibility to provide us with insurance forms assigning payment to this office and you are responsible for balances not covered by your policy on the day of service.

Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer. At your request, this office will provide all pertinent information to your insurance company and we will do our best to help you derive the maximum benefits available. However, we are not responsible for determining what those benefits are to be.

- Some policies require a "pre-authorization" before treatment is begun. We will submit a treatment plan for review by your insurance company if this is a requirement.
- Please remember that dental insurance is designed to assist people to obtain dental care and rarely covers more than 1/3 to 1/2 of the cost of service. There may be a deductible, a co-insurance factor, and a yearly maximum amount to be considered.
- Most policies cover what they consider a "usual and customary fee". However, the insurance company sets these fees, and they are not always the same as the fees that may be charged by this office.

All these factors may contribute to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan. However, ultimate responsibility for payment is yours and financial arrangements must be defined before dental treatment can begin.

In order to assist you with your health care investment, we are providing the following payment options:

- **CASH** – includes money orders, personal checks and debit.
- **VISA/MASTERCARD/DISCOVER/AMEX** – we accept credit cards as payment to the extent your credit limit permits.
- **CARE CREDIT** – offers a separate line of credit to cover your entire family's health care needs.
    - A credit line can be established and approval usually takes less than 10 minutes.
    - Care Credit has an interest free option.
    - There is no annual or membership fee.

We would be happy to work with you to plan the most appropriate arrangements for your budget.

Thank you.

Please Sign that you have read and understand this information:

PRINT NAME _______________ SIGNATURE _______________

Greenfield
FAMILY DENTISTRY P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

____
(Please Print Name of Minor Dependent if applicable)

____
(Signature)

____
(Date)

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 acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

____

YOUR CHILD'S DENTAL VISIT

We are so excited that you have placed your trust in the staff at Greenfield Family Dentistry, PC, to take care of your child's dental needs. Please read the following information carefully.

Parents are welcome to accompany and stay with their child in the treatment area during the **initial examination.** This gives you the opportunity to see our staff interact with your child and allows Dr. Herr the opportunity to meet the parents and discuss findings and treatment needs with you. We do ask that if you accompany your child that you assume the role of a silent observer. Your presence is greatly enhanced if you play a passive role. If more than one person is speaking to your child, they may become confused. Cooperation and trust must be established between Dr. Herr and your child. We also ask that siblings remain in the reception area. If your child must return for fillings or other dental treatment, parents may bring their child back to the treatment area, but **must return to the reception area** while the dental work is completed. We have found that typically children do better without a parent present during the operative appointment. Children who may be apprehensive may look for an escape by going to their parents. The following is a brief explanation of some of the methods we use to guide your child's behavior and provide a positive dental experience.

TELL, SHOW, DO

This is the most important tool for teaching your child. The child is told in simple terms what is going to be done during the dental visit. We show them some of the instruments and materials we will be using. For example, we will show your child "Mr. Whistler" (the dental drill) and show them how Mr. Whistler squirts water and makes a whistling noise.

IMAGERY

We tell the child in simple terms what is going to be done. For example, a dental exam becomes "looking and counting your teeth". A dental cleaning becomes "brush and tickle your teeth".

DISTRACTION

Sometimes it is necessary to distract your child from an unpleasant sensation by focusing his/her thoughts on something other than what is being done.

POSITIVE REINFORCEMENT

This is a technique used to reinforce good behavior by praising your child.

VOICE CONTROL

Voice control is a controlled change of voice volume, tone, or pace to influence and direct the child's behavior. This technique is used to establish a line of communication between the doctor and the child.

LOCAL ANESTHESIA

Most restorative procedures require the use of local anesthetic. We refer to local anesthetic as "sleepy juice". Please avoid using words such as "shot, needle, or injection". We never use these words around children. A topical anesthetic is used to help numb the soft tissue at the injection site. The child is told that we are going to put some sleepy juice around their tooth so the cavity bugs can be cleaned off. The dental assistant places their arm lightly across your child's chest or holds their hands during the injection to protect the child from reaching up and grabbing the syringe and hurting themselves.

NITROUS OXIDE AND OXYGEN SEDATION

If your child is nervous, wiggly, or anxious about his/her dental visit, we may recommend the use of nitrous oxide (laughing gas) to help your child relax and have a more pleasant dental visit. Nitrous oxide is a safe and extremely effective method of helping children (and adults) relax during treatment. It has a quick onset, and recovery takes about 5 minutes. We will tell your child that we will be placing a "space mask" over their nose, and to breath normally thru their nose.

BEHAVIOR

We realize and understand that children can be nervous and scared about visiting the dentist. We will try to make your child feel as safe and comfortable as possible. For the safety of your child and the office staff, we will ask your child to keep their hands by their sides, or maybe under their bottom. A child that yells, will not listen to Dr. Herr or the staff, or is not behaving properly, may need to be rescheduled, or possibly referred to a pediatric office for deeper sedation.

SCHEDULING APPOINTMENTS

When scheduling a dental appointment for your child, we encourage you to schedule a morning appointment. We realize that scheduling in the morning may be in direct conflict with school, however, children have a better dental experience when they are fresh and not tired from a long day at school.

I have read and understand the information above.

Print name: ______________________________

Signature: ______________________________

Relationship: ______________________________

Date: ______________________________