GREENFIELD FAMILY DENTISTRY
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 ☐ Specialty Office
☐ Work ☐ Google ☐ Social Media ☐ Other _____

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

Name: **Health Information** **Date:**

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

- ☐ AIDS/HIV
- ☐ Alzheimers
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism/ADHD
- ☐ Autoimmune
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain (angina)
- ☐ Convulsions
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack/Failure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral valve prolapse
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Persistent Cough
- ☐ Radiation Treatment
- ☐ Recent weight loss, fever, night sweats
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Ankles/Limbs
- ☐ Thyroid Disease
- ☐ Tonsilitus
- ☐ 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 need to take pre-medication prior to dental appointment?	☐	☐
• 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

GREENFIELD FAMILY DENTISTRY
DANIEL MASTERS, DMD

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 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 –** cash, 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

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}

_____
{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)

GREENFIELD
FAMILY DENTISTRY

Daniel Masters, DMD

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/dental information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Greenfield Family Dentistry to release my records and any information requested to the following individuals.

1. _____ Relation to Patient:_____
2. _____ Relation to Patient:_____
3. _____ Relation to Patient:_____

Authorization Regarding Messages
(please check all that apply)

____ I authorize you to leave a message with anyone who answers the phone
____ Messages may only be left with _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature