GREENFIELD
FAMILY DENTISTRY

YOUR CHILD'S DENTAL VISIT

We are so excited that you have placed your trust in the staff at Greenfield Family Dentistry to take 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 Masters 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. Masters 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.

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

LOCAL ANESTHESIA
Most restorative procedures require the use of local anesthetic. We refer to the 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 hold 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 breathe 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 or will not listen to Dr. Masters 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: _____

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** **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, P. C.
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, 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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for a copy of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mail, texts, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Pam Hankel

Telephone: 480-632-6999 Fax: 480-632-6997

Address: 875 N. Greenfield Road Suite 114 Gilbert, AZ 85234

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)

_____

_____