

Name: _____

Health Information

Date of Last Dental Visit: _____

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

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

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

- | | Yes | No |
|--|--------------------------|-------------------------------|
| <input type="checkbox"/> Do you use tobacco products? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Do you feel any pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Do you have any sores/lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 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.
Bruce L. Herr, JR, DDS

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 to

Please Print Name

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

_____ 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** – 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:
