



Name: \_\_\_\_\_

## Health Information

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,<br>fever, night sweats | OTHER:<br><input type="checkbox"/> _____      |
| <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"/> 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

Date of Last Dental Visit: \_\_\_\_\_

- |  | 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  
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.

\_\_\_\_\_  
Signature of patient, parent or guardian      Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
PRINT Name of guarantor of payment/responsible party

\_\_\_\_\_  
Signature of guarantor of payment/responsible party      Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# 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:

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PRINT NAME

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SIGNATURE



## 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)

<b>For Office Use Only</b>
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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, P.C.

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## NOTICE OF PRIVACY PRACTICES

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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.

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### **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.

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### **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, postcards, or letters).

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### **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.

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### **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: Debbie Kavanagh

Telephone: 480-632-6999

Fax: 480-632-6997

Address: 875 N. Greenfield Road Suite 114

Gilbert, AZ 85234