Kenneth M. Greenberg, D.D.S. & Nancy E. Freibaum, D.D.S., P.A.
8529 Gunn Highway
Odessa, Florida 33556
(813) 920-6608

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

Your appointment, will take approximately 1 hour. To facilitate being seen just as soon as possible at the time of your appointment, we would appreciate it if you would complete the enclosed Patient Information Form before your arrival. Please remember to bring it with you.

If you are unable to make the appointment you have scheduled with us, please notify us at least 24 hours in advance and we will reschedule it for you. In the meantime, we look forward to meeting you and serving your needs.

Thanks again for choosing our dental practice.

Sincerely,

Kenneth M. Greenberg, D.D.S. &
Nancy E. Freibaum, D.D.S., P.A.

P.S. **If you have dental insurance, please remember to bring this information with you to your appointment, along with a list of any medications and supplements you are currently taking.**

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NANCY E. FREIBAUM, D.D.S., P.A.

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WELCOME

So that we may provide you with the best possible care, please complete both sides of this form.
All information is strictly confidential.

PATIENT INFORMATION

Patient Name		Nickname	
Social Security No.	Date of Birth / /	Age	Male ❑ Female ❑
Marital Status Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑		Race	
Address		Apartment No.	
City	State	Zip Code	
Home Phone No.	Cellular Phone No.	E-Mail Address	
Work Phone No. Ext.		Occupation	
Employer			
Driver's License No.	State		
Method of Payment Cash ❑ Check ❑ Visa ❑ Mastercard ❑ Discover ❑ Interested in Financing Option ❑			

SPOUSE/PARENT (GUARDIAN) INFORMATION

Spouse/Parent (Guardian) Name	Social Security No.
Employer	Work Phone No. Ext.
Do you have dental insurance? Yes ❑ No ❑	
If yes, name of Insurance Co.	
Insurance Co. Address	Insurance Co. Phone No.
Name of Insured	Policy or Group No.
Social Security No. of Insured	Insured's Employer

GENERAL INFORMATION

How did you hear about our office?	
Purpose of Appointment	
In case of emergency, who should be notified?	
Phone No. Work Phone No.	Relationship
Other family members seen in our office	

Your appointment time is reserved exclusively for you. If you are unable to keep an appointment, kindly give our office 24 hours notice. A fee may be assessed for repeated missed appointments without prior notice. Please note that fees are due when services are rendered. In the event that a delinquent account must be turned over for collections, patient or responsible party agrees to pay account balance and all additional costs for collection.

Patient/Responsible Party Signature _____ Date _____

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Name of Physician	Physician Phone No.
Are you under the care of a physician now? Yes ❑ No ❑	Date of last physical
If so, for what reason?	

Do you have, or have you had:

Yes	No		Yes	No	
❑	❑	Rheumatic Fever	❑	❑	Respiratory Disease
❑	❑	Heart Murmur	❑	❑	Hemophilia/Blood Disorder
❑	❑	Mitral Valve Prolapse	❑	❑	Thyroid Disease
❑	❑	Heart Pacemaker	❑	❑	Liver Disease/Jaundice
❑	❑	Heart Valve Replacement	❑	❑	Asthma
❑	❑	Heart Bypass Surgery	❑	❑	Emphysema
❑	❑	Artificial Joints/Pins	❑	❑	Stroke
❑	❑	Transplant	❑	❑	Diabetes
❑	❑	Heart Disease	❑	❑	Special Diet
❑	❑	High Blood Pressure	❑	❑	Epilepsy/Seizures
❑	❑	Ulcers	❑	❑	Allergies
❑	❑	Tuberculosis	❑	❑	Back Problems
❑	❑	Arthritis	❑	❑	Blood Transfusion Year ____
❑	❑	Glaucoma	❑	❑	Substance Abuse
❑	❑	Chemotherapy	❑	❑	Anemia
❑	❑	Radiation Therapy	❑	❑	Venereal Disease
❑	❑	Frequent or Severe Headaches	❑	❑	HIV/AIDS/ARC
❑	❑	Chronic Diarrhea	❑	❑	Psychiatric Treatment
❑	❑	Sinus Problems	❑	❑	Hepatitis Year _____Type ___
❑	❑	Swollen Neck Glands			**WOMEN**
❑	❑	Do you smoke?	❑	❑	Are you pregnant?
			❑	❑	Are you nursing?
			❑	❑	Oral Contraceptives?

Are you taking any medications? Yes ❑ No ❑ If so, please list:

Do you have any other medical conditions? Yes ❑ No ❑ If so, please list:

Do you have, or have you had:

Yes	No		Yes	No	
❑	❑	Sensitivity to Hot/Cold/Sweets	❑	❑	Grinding/Clenching Teeth
❑	❑	Pain when you bite	❑	❑	Popping/Clicking/Pain when moving jaw
❑	❑	Sore areas in mouth	❑	❑	Tired Jaws/Muscles
❑	❑	Bleeding/Painful Gums	❑	❑	Headaches/Neckaches
❑	❑	Loose Teeth/Change in bite	❑	❑	Shoulder Aches/Sore Muscles
❑	❑	Bad Breath	❑	❑	A bite plate/guard
❑	❑	Cold Sores/Blisters/Oral lesions	❑	❑	Periodontal Treatment
❑	❑	A Serious Injury to the mouth or head If so, please explain:	❑	❑	Orthodontic Treatment

Are you allergic to or have you ever had a reaction to:

Yes	No	
❑	❑	Penicillin
❑	❑	Erythromycin
❑	❑	Aspirin
❑	❑	Acetominophen
❑	❑	Codeine
❑	❑	Local Anesthetic/Injections
❑	❑	Other Medication or Drugs

If yes, which ones:

Date of last dental visit: What was done at your last dental visit?

Please describe anything about having dental treatment you would like us to know

Has local anesthetic been used for dental procedures? Yes ❑ No ❑

Are you satisfied with the color and appearance of your teeth and smile? Yes ❑ No ❑

Would you like to improve the color and appearance of your teeth? Yes ❑ No ❑

Do you participate in any sporting activities? Yes ❑ No ❑ If so, which?

I certify that, to the best of my knowledge, the above information is accurate and complete and I will not hold the dentists or any member of his/her staff responsible for any errors or omissions. I further authorize treatment by Drs. Greenberg and Freibaum and/or such other persons as they may appoint to assist them.

Signature of Patient or Guardian _____ Date _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____**Birthdate**_____

My health/dental information may be shared with the following individual(s).

_____ _____

Signature_____

Date_____

Dental Pros of Tampa

Kenneth M. Greenberg, D.D.S. & Nancy E. Freibaum, D.D.S., P.A.

Appointment Scheduling Policy

Thank you for choosing our office for your dental care. Our commitment is to provide personalized attention and to make each visit comfortable. Therefore, we schedule adequate appointment time for our patients based on their individual needs. Please help us maintain a high level of service and contain costs by selecting appointment times you can keep. In the event that you must reschedule or cancel an appointment, at least 24 hours' notice is required. Appointments which are missed or cancelled without sufficient notice may result in additional fees (minimum $50 per appointment) and require prepayment for future visits.

Patients may call during regular office hours to schedule, reschedule or cancel an appointment. Our office is open Monday through Friday. As a courtesy, you will be notified of your upcoming appointment but it is still the patient's responsibility to keep their appointment or give proper notification for all cancellations. By signing this form you give our office permission to contact you via phone, email, and text message. Unfortunately, we cannot accommodate cancellations or rescheduling requests made by voicemail, text, or e-mail.

Should you have any questions regarding this policy, please let us know. Thank you for your cooperation and for entrusting us with your dental care.

I have read and understand the above office policy.

I give permission to Dental Pros of Tampa to contact me by phone, email or text.

_____ _____

Signature of Patient (18 or over), Parent, or Legal Guardian **Date**

Dental Pros of Tampa

Kenneth M. Greenberg, D.D.S. & Nancy E. Freibaum, D.D.S., P.A.

Financial Policy

In addition to providing a comfortable, clean and courteous environment, we feel it is important to outline our financial policy for our patients.

It is customary to receive payment in full at the time services are rendered. However, if you have dental insurance, we will collect your estimated portion and submit for reimbursement from your insurance company provided we have up-to-date coverage information. In the event that we cannot get this information prior to your visit, you will be responsible for payment in full.

We pride ourselves on providing quality dental care. Multiple payment options are available. Our staff will be happy to discuss the options which may fit your needs. Please note that payment arrangements may only be made *prior* to initiation of treatment.

A finance charge of 1.5% monthly (18% APR) will be assessed to overdue accounts. In the event that a delinquent account must be turned over for collections, patient or responsible party agrees to pay account balance and additional costs for collection.

_____

Print Patient Name

_____ _____

Signature of Patient or Responsible Party **Date**

Dental Pros of Tampa

INSURANCE ASSIGNMENT POLICY

Thank you for choosing Dental Pros of Tampa. Please read the following information carefully and please ask if you have any questions before signing.

Your dental insurance is an agreement between you and the insurance company. As a courtesy to our patients we will be happy to assist you with filing dental claims. A patient co-payment estimate is derived from information supplied by your insurance company. The patient will pay the estimated portion at the time of service.

If the patient has a secondary insurance policy, our office can accept assignment on the primary insurance only. If your insurance provider does not pay benefits to our office directly, the patient is responsible for full payment at the time of service. We will still file all insurance claims for the patient to be reimbursed. In the event that the actual insurance reimbursement is less than estimated, the unpaid account balance is the sole responsibility of the patient /responsible party.

Although we do accept many insurance plans and PPOs, our office has no in network agreementswith any insurance company except Delta Dental and Cigna DPPO.

Any changes in your insurance policy or coverage must be brought to our attention prior to your dental visit. In addition, we are not responsible for the accuracy of the information given to us by your insurance company or for any exclusions, limitations or waiting periods included in your policy. Any questions regarding your policy terms or benefits should be directed to your insurance company or employer.

By signing below, I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Kenneth M. Greenberg, D.D.S. & Nancy E. Freibaum, D.D.S., P.A. I also hereby authorize said assignee to release all information and duplicate radiographs as necessary to secure payment. (A photocopy of this agreement is considered as valid as the original).

I agree to be responsible for any balance remaining on my account after insurance reimbursement. I understand thataccount balances are due within 30 days of initial billing. Overdue balances may be subject to finance charges at a rate of 1.50% a month.

A copy of this agreement may be obtained by request.

Thank you for your cooperation and for choosing Dental Pros of Tampa.

_____ _____

Signature of Patient or Responsible Party Date