Daniel Family Dentistry
Patient Registration

Patients First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Date of Birth: _____

Patient is covered by dental insurance: Yes / No Patient is responsible for payment: Yes / No

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Ph: _____ Work Ph: _____ Ext: _____ Cell: _____

Sex: M / F Marital Status: Married / Single / Minor

Social Security Number: _____ Driver's License Number: _____

Email: _____

Employment Status: Full Time / Part Time / Retired Student Status: Full Time / Part Time

Employer: _____ School: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____ 2nd Contact Number: _____

Who can we thank for referring you to our office? _____

If the Patient is **NOT** responsible for payment, please complete this section:
Responsible Party
First Name: _____ MI: _____ Last Name: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Home Ph: _____ Work Ph: _____ Ext: _____ Cell: _____
Social Security Number: _____ Driver's License Number: _____
Email: _____

If the **Patient has Dental Insurance**, please complete this section:
Policy Holder's Name: _____ Patient Relationship to Policy Holder: _____
Policy Holder's SSN: _____ Policy Holder's DOB: _____
Employer: _____
Employer's Address: _____
Insurance Company: _____ Group Number: _____
Insurance Company Address: _____

If the Patient has **Secondary Dental Insurance**, please complete this section:
Policy Holder's Name: _____ Patient Relationship to Policy Holder: _____
Policy Holder's SSN: _____ Policy Holder's DOB: _____
Employer: _____
Employer's Address: _____
Insurance Company: _____ Group Number: _____
Insurance Company Address: _____

MEDICAL HISTORY

Patients Name: _____ Patient DOB: _____

Physician's Name: _____ Phone_____

Have you had any medical care within the past two years? ☐Y ☐N If yes, then please explain_____

Are you currently taking any medications, drugs, pills, or herbal remedies? ☐Y ☐N If yes, then please list_____

Are you aware of having an allergic reaction to any substance or medication? ☐Y ☐N If yes, then please describe_____

Indicate which of the following you **<u>have had</u>** or **<u>have at present</u>**. **Check Y/N to each item**.

☐Y ☐N Heart (Surgery, Disease, Attack)	☐Y ☐N Kidney Trouble	☐Y ☐N Venereal Disease
☐Y ☐N Chest Pain	☐Y ☐N Ulcers	☐Y ☐N AIDS/HIV Positive
☐Y ☐N Congenital Heart Disease	☐Y ☐N Diabetes	☐Y ☐N Cold Sores Fever Blisters
☐Y ☐N Heart Murmur	☐Y ☐N Thyroid Problems	☐Y ☐N Blood Transfusion
☐Y ☐N High or ☐Low Blood Pressure	☐Y ☐N Glaucoma	☐Y ☐N Hemophilia
☐Y ☐N Mitral Valve Prolapse	☐Y ☐N Emphysema	☐Y ☐N Sickle Cell Disease
☐Y ☐N Artificial Heart Valve/Pacemaker	☐Y ☐N Chronic Cough	☐Y ☐N Liver Disease
☐Y ☐N Rheumatic Fever	☐Y ☐N Tuberculosis	☐Y ☐N Neurological Disorders
☐Y ☐N Arthritis/Rheumatism	☐Y ☐N Asthma	☐Y ☐N Epilepsy or Seizures
☐Y ☐N Hay Fever/Allergy/Hives	☐Y ☐N Latex Sensitivity	☐Y ☐N Fainting or Dizzy Spells
☐Y ☐N Swollen Ankles	☐Y ☐N Sinus Trouble	☐Y ☐N Nervous/Anxious
☐Y ☐N Diet (Special/Restricted)	☐Y ☐N Radiation Therapy	☐Y ☐N Cancer/Chemotherapy
☐Y ☐N Hepatitis A,B,C	☐Y ☐N Artificial Joints	☐Y ☐N Psychiatric/Psychological Care

Do you have or have had any disease, condition, or problem not listed? ☐Y ☐N If yes, then please explain_____

Women: Are you pregnant? ☐Y ☐N Months_____ Nursing? ☐Y ☐N

Do you use prescription birth control? ☐Y ☐N

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, then you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian: _____ Patient/Guardian: _____

Printed Name Signature Date

DENTAL HISTORY

Patients Name: _____ Patient DOB: _____

What is the reason for your visit today? _____
_____

Date of last dental visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays_____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address_____ State_____ Zip Code _____

How often do you brush your teeth? _____ How often do you floss? _____
Do you have any dental problems now? ☐Y ☐N If yes, then please describe_____
_____

Have you ever been told to take pre-medication prior to dental treatment? ☐Y ☐N

Are any of your teeth sensitive to:
Hot or Cold? ☐Y ☐N Biting or Chewing? ☐Y ☐N Sweets? ☐Y ☐N

Do you:
Snore or have sleeping disorders? ☐Y ☐N Smoke/Chew tobacco or tobacco products? ☐Y ☐N
Clinch/grind your teeth? ☐Y ☐N Feel nervous about having dental treatment? ☐Y ☐N

Have you ever had:
Periodontal treatment? ☐Y ☐N Oral surgery? ☐Y ☐N Orthodontic Treatment? ☐Y ☐N
An upsetting dental experience? ☐Y ☐N If yes, then please describe_____
_____

Is there anything else about having dental treatment that you would like for us to know? ☐Y ☐N
If yes, then please describe_____

Patient/Guardian: _____ Patient/Guardian: _____
Printed Name Signature Date

APPOINTMENTS~OFFICE POLICY

~**Once an appointment is made, please remember that this time is reserved specifically for you.**
~If you must change your appointment time, then Daniel Family Dentistry ***requires a 48 hour (at least 2 business days) notice on any cancellation or rescheduled appointment.*** (Legitimate emergencies are exceptions)
~**We reserve the right to assess a fee for time reserved** for an appointment in which two-business days' notice is not provided in our office. This fee can range from a minimum of ***$35.00 to a maximum of $250 per half hour, for routine preventative and restorative procedures. For longer more complex restorative and cosmetic procedures, the fee will be determined on case by case basis.***
~**Cancellations** or appointment changes ***MUST*** be handled by a **Staff Member** and ***NOT*** via our voicemail system, email, or MOJO notification.
~PLEASE, PLEASE CONFIRM YOUR HYGIENE APPOINTMENTS, as they are scheduled **6 Months** in advance, and we understand there maybe changes in your personal schedule. Therefore, we will continue to make every effort to contact you, but if you do not respond, then we may cancel your appointment and charge you a fee. **If you are more than 10 Minutes late to your Hygiene Appointment**, your appointment **will be Cancelled**, and you may be charged a fee.

PAYMENT AGREEMENT

~We **accept** cash, personal check, MasterCard, Visa, American Express, or Discover card. We do **NOT** accept postdated checks.
~Extended payment plans and interest free financing plans are available through **Care Credit**.
~Daniel Family Dentistry will make every effort to minimize bookkeeping errors. Should an error result in a debt owed to us we will provide correct statement and allow an additional 10 days for payments to be rendered in full. Should an error result in a credit, you may leave the credit on your account or request a refund. We will process requests within 10 business days.
~In the event payment is not received by the agreed upon dates, I understand that my account may be subject to a ***1.5% finance charge per month 18% finance charge per year and that I may also be responsible for $30 monthly rebilling fee.***
~ I accept all fees as lawful debt for services rendered and promise to pay all said fees

COLLECTIONS

~Daniel Family Dentistry reserves the right to assess a services charge of $40 for all returned checks (or maximum allowed by law).
~Daniel Family Dentistry also reserves the right to forward any and all accounts over 90 days due to an outside collection agency.
~I the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any all/necessary ***collection agency fees (33.33%),*** attorney fees and court costs, if such be necessary.
~I waive now and forever my right/all rights of exemption under laws of the constitution of the State of Alabama and any other state.
~I authorize Daniel Family Dentistry to contact me at any numbers including my cell phone for the purpose of treatment, insurance or payment for services rendered.
~I further authorize Daniel Family Dentistry to receive and exchange credit information for collection purposes.
~I hereby authorize the release of medical information for all insurance claims and payment of my group insurance benefits, otherwise payable to me, to the dentist.
~I further agree to accept and adhere to the above office policy of Daniel Family Dentistry.

Patient/Guardian: _____ Patient/Guardian: _____
Printed Name Signature Date

Witness by Staff Member: _____
Signature Date

For Patients with Dental Insurance

~If you have dental coverage, Daniel Family Dentistry will file your claims as a courtesy to you.

~Most dental insurance plans are a business agreement between an insurance company and an employer. It is important to remember that reimbursement and benefit levels are based on carrier and employer business decisions and not an individual's need for treatment.

~Most dental plans exclude coverage for cosmetic treatment such as teeth whitening and veneers. Many have age or frequency limitations on services such as fluoride treatments or dental sealants.

~Some dental plans do not offer coverage for pre-existing conditions such as missing teeth. This type of plan would not cover prosthetic tooth replacement procedures such as bridges, partial dentures, full dentures or dental implants. Most dental plans also have waiting periods for replacement of existing crowns, bridges, or dentures.

~Many insurance plans will apply "alternate benefits" towards a service, such as paying for silver fillings (amalgams) rather tooth-colored fillings (composites), or major restorative services, such as crowns, inlays or onlays and paying for regular fillings instead.

~***WE DO NOT*** render our services on the basis that insurance will pay any or all of our fees.

~Please be aware that all professional services rendered are charged directly to the Patient/Responsible Party and the Patient/Responsible Party is personally responsible for all of our fees.

~All patient co-payments and deductibles, as required by your specific insurance coverage are due and payable at the time of EACH VISIT.

~***YOU*** are responsible for providing us with accurate insurance information at the time of service. Failure to do so could result in your claim being rejected or delayed. Repeat filling of duplicate insurance claims due to inaccurate or inadequate information provided by you may be subject to a re-filing fee of ***$25.00 per claim***.

~If payment of your claim has not been received ***for any reason*** with ***45 days from the date of service***, you the Patient/Responsible Party will be responsible for any unpaid balance.

~If your insurance company pays less than the estimated benefit, you will be responsible for any unpaid balance.

~If your insurance company pays more than the estimated benefit, you may have a credit balance on your account. At such time that we determine the payment was in error, you may either leave the credit on your account to be applied to charges for future dental care, or you may request a refund. Daniel Family Dentistry will make every effort to process refund request within 10 business days from the date request is received.

~By signing, you also authorize payment for dental services by insurance company be released to Dr. J. Edward Daniel, of Daniel Family Dentistry.

Patient/Guardian: _____ Patient/Guardian: _____
Printed Name Signature Date

Witness by Staff Member: _____
Signature Date

Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Further, I understand that I am entering into a contractual relationship with Dr. J. Edward Daniel for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care
and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by Dr. Daniel, I, agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Dr. Daniel.

Furthermore, should a dental malpractice case or cause of action be initiated or pursued, I agree to use expert witness (es) who practice primarily in the same specialty as Dr. Daniel. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the Alabama Dental Association. In further consideration for this, Dr. Daniel agrees to the same stipulations.

I acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Doctor's reputation and business. Both Dr. Daniel and I agree in the event of a breach to allow specific performance and/or injunctive relief.
As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Consent Form for General Dental Procedures (Continued)

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment
2. Infection in need of medication, follow-up procedures or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste
4. Damage to adjacent teeth, restorations or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need for replacement of restorations, implants or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. A root tip, bone fragment or a piece of a dental instrument maybe left in your body, and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient/Guardian: _____ Patient/Guardian: _____
Printed Name Signature Date

Witness by Staff Member: _____
Signature Date

Acknowledgement of Receipt of
Notice of Privacy Practices

I have received a copy of Daniel Family Dentistry's Notice of Privacy Practices.

Please Print Full Name:(Patient, or parent/guardian/power of attorney)

Legal 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)

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 06/01/2018** 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 additional copies of this notice, please contact us using the information 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 for 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 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 also 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 official's 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, text messages or e-mail).

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. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.25 per page, and $15 per hour or part of an hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. 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 June 1, 2012. 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 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 handles 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. 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	**Donica Lovelace, Office Manager**
Telephone	**205.967.0760**
Fax	**205.967.7166**
Address	**3161 Cahaba Heights Road** **Suite 201** **Birmingham, Alabama 35243**