PERSONAL INFORMATION

PATIENT

NAME_____ DATE OF BIRTH____/____/_____
First M.I. Last

ADDRESS_____ SS# _____
Street number

_____ Cell Phone(_____)_____
City State ZIP

DRIVER'S LICENSE #_____ STATE_____ Work Phone (____)_____

E-MAIL ADDRESS_____ MARRIED □NO □YES, SPOUSE'S NAME_____

RESPONSIBLE PARTY

□ (Check here if same as above)

If insured, this should be the same as the insured party.

RELATIONSHIP TO PATIENT □SPOUSE □PARENT □OTHER_____

NAME_____ DATE OF BIRTH____/____/_____
First M.I. Last

ADDRESS_____ SS# ---------- _____
Street number

_____ Cell Phone(_____)_____
City State ZIP

DRIVER'S LICENSE #_____ STATE_____ Work Phone (____)_____

E-M AIL ADDRESS_____ MARRIED □NO □YES, SPOUSE'S NAME_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____ EMPLOYER_____

NAME OF INSURED_____ DOB____/____/_____ SS#_____

SECONDARY INSURANCE COMPANY_____ EMPLOYER_____

NAME OF INSURED_____ DOB____/____/_____ SS#_____

PLEASE READ CAREFULLY

By signing below, you agree to the following:

- To be responsible for any and all charges incurred for treatment of the above named patient
- To pay the estimated patient portion at the day treatment is initiated, including deductible, co-pay, and other charges insurance does not cover.
- Any dental insurance coverage estimates are good faith estimates only. We cannot guarantee to what extent your insurance company will pay for any given procedure. You are fully responsible for any balance not paid by insurance.
- To call no less 48 hours in advance of any appointment you cannot keep. Failure to do so will subject you to a $35.00 fee.
- To consent to treatment for the above named patient after specific treatment options are discussed, and you have been given the opportunity to accept or reject any particular recommendations made by Dr. Daniel.
- To pay any attorney's fees, court costs, and other costs of collection incurred in any effort by Dr. Daniel to collect for services performed

X_____ /____/____
Signature Date

DENTAL/MEDICAL QUESTIONNAIRE

Are you anxious/afraid of having dental work done? □ Yes □ No

Are you interested in sedation if you have any dental treatment to be done? □ Yes □ No

Do you currently have any tooth problems-
pain, missing fillings, broken teeth, missing teeth you want replaced? □ Yes □ No

Is there anything you would like to change about the appearance of your smile
spacing, crowding, discoloration? □ Yes □ No

How long has it been since your last dental cleaning? _____

How did you hear about us? (friend/family members name, Postcard, Billboard, Radio, etc)

_____

Do you have any of the following now or in the past?(***Please mark yes or no, do not leave blank***.)

□y □n Asthma □y □n Allergies(food or drug allergies) □y □n Anemia/vitamin deficiencies □y □n Angina/chest pains □y □n Arthritis □y □n Artificial Joints □y □n Blood Disease □y □n Cancer / Tumor / Malignancy □y □n Diabetes □y □n Dizziness / Vertigo □y □n Emphysema / Tuberculosis □y □n Epilepsy / Seizures	□y □n Excessive Bleeding/hemophilia □y □n Fainting □y □n Glaucoma □y □n Head Injuries □y □n Heart Disease □y □n Heart Murmur □y □n Heart Surgery □y □n Hepatitis / Jaundice □y □n High Blood Pressure □y □n HIV / AIDS □y □n Kidney/Liver Disease □y □n Mitral Valve Prolapse	□y □n Pacemaker □y □n Pregnancy □y □n Radiation Treatment □y □n Respiratory Problems □y □n Rheumatic Fever □y □n Rheumatism □y □n Sinus Problems □y □n Stomach / Intestinal Disorders □y □n Stroke □y □n Thyroid Problems □y □n Ulcers

Are you currently:

pregnant? no□ yes□

under the care of a physician? no□ yes□(name)_____

required to take antibiotics prior to dental visits? no□ yes□ (please specify condition)_____

taking any medications? (**including** over the counter drugs and birth control) no□ yes□

(please list):_____

_____

Are you allergic to any of the following? Please mark all that apply ***or check here for none***: □

- □ Aspirin
- □ Codeine
- □ Epinephrine
- □ Latex
- □ Lidocaine or other dental anesthetics
- □ Penicillin
- □ Benzodiazepines (Valium, Versed, Halcion, Xanax, Ativan, etc.)
- □ Other (specify)_____

Is there anything about your health not specified above that you feel we should know about? □No □Yes (specify below)

_____

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.

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 may be 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 Date	Witness Date
_____	_____
Print Patient Name	Parent/Legal Guardian Date

Daniel Family Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office'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 10/01/2002, 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 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, 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 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 additional request.

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.

Office Contact:

Beth Ann Daniel
205-967-0760
drdanieldentistry@gmail.com

Employment and Insurance

Employer Information

EMPLOYER NAME_____

EMPLOYER ADDRESS

Street Address_____

City, State, Zip_____

EMPLOYER PHONE (___)_____-_____ext#_____

Assignment of Insurance Benefits

I hereby authorize payment of dental benefits otherwise payable to me directly to:

J. Edward Daniel, DMD

_____

Signed Date

I also hereby authorize the release of any information in my dental record to my insurance company for the purposes of determining the eligibility of treatment for benefits paid by my insurance company.

_____

Signed Date