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)