McDaniel Family Dentistry

Today's Date: _____

NEW PATIENT INFORMATION

PATIENT LEGAL NAME: _____ PREF. NAME: _____ SS#:_____

ADDRESS: _____ CITY: _____ STATE:_____ ZIP:_____

PHONE NUMBER: (H):_____ (C):_____ E-MAIL:_____

PREFERRED CONTACT METHOD: Phone: ☐ Cell ☐ Home ☐ Text ☐ E-Mail

SEX: ☐ Male ☐ Female ☐ Prefer not to say DATE OF BIRTH: _____ AGE:_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widow

EMPLOYER: _____ OCCUPATION: _____

PREF. PHARMACY: _____

EMERGENCY CONTACT: Name:_____ Phone: _____

*Whom may we thank for referring you?:_____

PRIMARY DENTAL INSURANCE

SUBSCRIBER: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER DOB: _____ SUBSCRIBER SS#: _____

ADDRESS (IF DIFFERENT FROM PATIENT): _____

ADDRESS (CONT) _____PHONE #: _____

SUBSCRIBER/GUARANTOR EMPLOYER:_____ OCCUPATION:_____

DENTAL INSURANCE COMPANY: _____ CONTACT #: _____

SUBSCRIBER/MEMBER ID: _____ GROUP #: _____

DENTAL INSURANCE CLAIMS ADDRESS: _____

DENTAL HISTORY

Are you in any discomfort today? ☐ Yes ☐ No If yes, please describe: _____

Check if you have had problems with any of the following:

☐ Bad Breath	☐ Food collection between teeth	☐ Periodontal treatments	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Grinding or clenching teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to hot	☐ Sores or growth in mouth
☐ Snoring			

How often do you brush? _____ How often do you floss?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?_____

_____

Other information about your dental health or previous treatment? _____

Would you be interested in talking to Dr. McDaniel about any of the following?

☐ Teeth Whitening	☐ Changing silver fillings to white	☐ Veneers
☐ Invisalign	☐ Vivera Retainers (invisible, removable retainers)	☐ Other: _____

McDaniel Family Dentistry

MEDICAL HISTORY

Primary Physician's Name:_____ Office #: _____

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No

If yes, please explain (including approx. dates): _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please explain (including approx. dates): _____

Do you have any food or drug allergies? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently pregnant? ☐ Yes ☐ No

Please list all medications you are currently taking: _____

_____

Please check if you have any of the following:

☐ AIDS	☐ Circulatory Problems	☐ HIV Positive
☐ Cortisone Treatments	☐ Jaw Pain	☐ Kidney Problems
☐ Anemia	☐ Epilepsy	☐ Skin Rash
☐ Arthritis	☐ Fainting Episodes	☐ Radiation Treatment
☐ Artificial heart valves	☐ Food Allergies	☐ Respiratory Disease
☐ Glaucoma	☐ Shortness of Breath	☐ Headaches
☐ Aspirin Daily	☐ Heart Murmur	☐ Stroke
☐ Asthma	☐ Swelling of feet or ankles	☐ Hemophilia
☐ Tuberculosis	☐ Venereal Disease	☐ Diabetes
☐ Blood Thinners		

☐ Artificial Joints; date of placement _____ ☐ Blood Disease: _____

☐ Heart Problems; _____ ☐ Pacemaker; date placed _____

☐ Ulcers: location: _____ ☐ Anaphylaxis; caused by: _____

☐ Any other conditions not listed: _____

PATIENT ACKNOWLEDGMENT AND AUTHORIZATION

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine the appropriate course of treatment. If any changes occur, I agree to inform the office as soon as possible.

If I have dental insurance, I authorize McDaniel Family Dentistry to file claims on my behalf and for my insurance company to make payment directly to the office. I also authorize the release of any necessary information to secure payment of benefits.

I acknowledge that McDaniel Family Dentistry is not in-network with any insurance providers. I understand that I am responsible for any fees not covered by my insurance, and the office will file my insurance to utilize out-of-network benefits.

Signature: _____ Date:_____

Name (Printed): _____ Relationship to Patient:_____

McDaniel Family Dentistry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THESE ARE FEDERAL REGULATONS. PLEASE REVIEW THEM CAREFULLY.

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 the Notice while it is in effect. This Notice takes effect 01/01/2004, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. The new Notice will be effective for all health information that we maintain, including health information we create or receive after the effective date. You may request an updated copy of our Notice at anytime. For more information about our privacy practices, or for additional copies of the Notice, please contact us by using the information listed 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 dentist, physician, or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you. For example, we will send the necessary information to your health or dental insurance company to obtain payment for the treatment.

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.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment. We may contact you by the following means of communication (1) mail, (2) telephone, (3) email, or (4) fax.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorizations 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 anytime. 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 the Notice or by law.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of the 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 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 fill prescriptions, medical supplies, x-rays, other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse of Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, 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 of the health or safety of others. Any disclosure will be made consistent with the requirements of applicable federal and state laws.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Inmates: We may use or disclose or disclose your health information if you are an inmate of a correctional facility and your facility created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of the Health and Human Services to investigate or determine our compliance.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as phone calls, voicemail messages, emails, text messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or receive a copy of your health information, with limited exceptions. (You must make a request in writing to obtain access to your health information. 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 $0.00 for the most recent and pertinent radiographs or $0.00 for a copy of the complete chart for staff time to locate and copy your health information, and postage if you want the copies mailed to you).

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. You must make this a restriction in writing and completely explain any and all restrictions you wish to be implemented to how we use your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (as required by law).

Disclosure Accounting: You have the right to receive a list of instances in which disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities but not before January 1, 2004 for up to the previous 6 years. 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.

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.

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.

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 of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to the U.S. Department of Health and Human Services.

Office Manager: Avery K. **Telephone**: 919-847-5959 **Email**: Mcdanielfamilydentistry@gmail.com **Address**: 7509 Six Forks Rd, Raleigh, NC 27615

McDaniel Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FEDERALLY MANDATED REGULATIONS REQUIRE THAT WE PROVIDE YOU WITH THIS INFORMATION. THANK YOU FOR YOUR ATTENTION AND COOPERATION TO THIS MATTER.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

I **do NOT** wish to be contacted by this office through the following means:

_____
(Please list ALL that apply, i.e.: text, email, phone, mail, etc.)

For Office Use Only (Do Not Fill Out This Section)

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

□ Communication barriers prohibited obtaining the acknowledgement

□ Other (please specify):

_____

_____

McDaniel Family Dentistry

AUTHORIZATION TO REALEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows **McDaniel Family Dentistry (formerly Parker and McDaniel Family Dentistry)** to communicate information about your care (e.g. appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, it is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____

Date of Birth: _____ Main Contact Number: _____

Mailing Address: _____

_____

COMMUNICATING WITH YOU

PHONE **DETAILED MESSAGES PERMITTED**

□ Main Contact Number Above □ text (SMS)* □ voicemail/answering machine □ none

□ Other: _____ □ text (SMS)* □ voicemail/answering machine □ none

EMAIL*

□ _____

□ All information from this practice □ Data breach notifications

□ Appointment information only (request/confirm/cancel) □ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

□ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: _____ Other: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

Check the box next to each type of information this practice may share.

□ All information □ Prescriptions □ Appointments (request/confirm/cancel) □ Billing/insurance

□ Other: _____

Do not include:

□ Mental health records □ Communicable diseases (e.g. HIV/AIDS) □ Alcohol/drug abuse treatment

*I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.

This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

McDaniel Family Dentistry

YOUR PHOTOS & MULTIMEDIA

□ Photo received from you or personal representative
□ Photo taken by staff (e.g. pre/post procedure)

Photos/Images may be used/posted:

□ In Office □ On office's website □ Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_____ _____

Patient/Personal Representative Signature: Date:

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

_____

FOR OFFICE USE & REFERENCE ONLY

□ This authorization has been terminated: _____
The termination must be in writing and filed with the original authorization .
Date original authorization received: _____
□ Copy of original authorization provided to patient/personal representative.

Notes: _____

_____

_____

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).