PATIENT INFORMATION

NAME	Married Single Male Fo	emale
ADDRESS		
CITY	STATE	ZIP CODE
PHONE (Home)	(Work)	
PHONE (Cell)	E-mail	
BIRTH DATE	SS#	
	inded of appts?Email onlyTe	
DRIVERS LICENSE NUMBER		
PLACE OF EMPLOYMENT		
IF FULL TIME COLLEGE STU	DET, SCHOOL NAME	
		GROUP#
Has any member of your family of		
office?		
Whom may we thank for referrin	g you to our	
office?		
Eathan (if min an)/Snauga/Doutnau	Mathan (if min on)/Smayaa/Doutnan	In an amanganay, contact,
Father (II minor)/Spouse/Partner	Mother (if minor)/Spouse/Partner	In an emergency, contact:
		Name
Last First M	Last First M	- (4
		Phone
Street City State/Zip	Street City State/Zip	
Home# Cell#	Home# Cell#	
Birthdate SS#	Birthdate SS#	

AUTHORIZATION

I certify that I have read or have had read to me the contents of this form. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member or her staff, responsible for any errors or omissions that I may have made in the completion of this form. The information on this page and the dental/medical histories are correct to the best of my knowledge.

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

I understand that I am responsible for all costs of dental treatment. We file insurance as a courtesy to our patients and are not responsible for what insurance does not cover or underpays. I hereby authorize my insurance benefits to be paid directly to the dentist. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I authorize that the doctor can use my records if he so determines.

I understand that I am responsible for keeping my scheduled appointments. Please allow our office 24 hours notice with any cancellations or rescheduling of appointments.

I have had full opportunity to read and consider the contents of this Consent Form, the Financial and Need to Change Appointment Policy, and Notice of Privacy Policies.

Signature				
Date				
Adult Patient	Father/Husband	Mother/Wife	Guardian	

Delaine Daniels, DDS **Eaglesoft Medical History**Birth Date:

Patient Name:

Date Created:

Date:_____

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ave you ever had a serious head or neck injury?			l a major	O Yes () No					
ave you take, or have you taken, Phen-Fen or Redus? Yes No If yes wave you ever taken Fosamax, Sonixa, Actonel or you shave you use tobacco? Yes No If yes No a you use tobacco? Yes No If		erious head or n	eck injury?	○ Yes ○ No If w		If γes				
we you ever taken Fosamax, Boniva, Actonel or you they other medications contraining bisphosphonates? e you use subbacco? Yes \ No Taking oral contraceptives?	Are you taking any medications, pills, or drugs?		r drugs?	O Yes ()No If yes					
you use tobacco? Yes No No Necent Weight Loss Yes No Recant Weight Loss Yes No Hempatils 8 or C Yes No Recant Weight Loss Yes No Herps Yes No High Blood Pressure Yes No Storake Fever Yes No Storake Fever Yes No No Storake Fever Yes No No Storake Fever Yes No Storake Fever Yes No No Storake Fever Yes No No Storake Fever Nes No Storake Fever Nes No No Storake Fever Nes No No Storake Fever Nes No No No Storake Fever Nes No	you take, or have y	ou taken, Phen-F	en or Redux?	O Yes ()No If ye	If yes				
e you on a special diet? Yes No Yes No Taking oral contraceptives? Tak				O Yes (ONC	If yes				
Penicillin	Are you on a special diet?		ospnonates?	O Yes (ONC	No				
Pregnant/Trying to get pregnant?	Do you use tobacco?			O Yes (ONC					
Penicillin		get pregnant?	Е	Nursing	?			□ Taking or	al contraceptives?	
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you have, or have you had, any of the following? AIDS/HIV Positive Yes No Diabetes Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes Anaphylaxis Yes No Easily Winded Yes No Angina Yes No Emphysema Yes No High Blood Pressure Yes No Recult Weight Loss Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Excessive Blood Disease Yes No Frequent Cough Yes No Blood Transfusion Yes No Genital Herpes Yes No Brequent Diarrhea Yes No Genital Herpes Yes No Genital Herpes Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Prequent Disease Yes No Prequent Disease Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Prequent Disease Yes No Prequent Disease Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Prequent Disease Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Prequent Disease Yes No Dispension Yes No	Metal		Latex				Sulfa Drugs		Local Anesthetics	
you have, or have you had, any of the following? AIDS/HIV Positive Yes No Diabetes Yes No Diabetes Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anaphylaxis Yes No Easily Winded Yes No Herpes Yes No Remail Dialysis Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever Yes No Artificial Joint Yes No Excessive Bleeding Yes No Blood Disease Yes No Bellood Transfusion Yes No Frequent Cough Yes No Brequent Diarrhea Yes No Brequent Diarrhea Yes No Brequent Headaches Yes No Genital Herpes Yes No Scarlet Fever Yes No Scheed Problems Yes No Schoody Intestinal Disease Yes No Brina Bifida Yes No Scroke Yes No Cancer Yes No Glaucoma Yes No Genital Herpes Yes No Cheest Pains Yes No Heart Attack/Failure Yes No Congenital Heart Disorder Yes No Heart Murmur Yes No Congenital Heart Disorder Yes No Heart Murmur Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Discharce Yes No Discharce Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Discharce Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Discharce Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Discharce Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Discharce Yes No Venereal Disease Yes Yes No Yes	Other?					If yes				
Alps/HIV Positive	o you use controlled	substances?		O Yes (ON C	If yes				
Alzheimer's Disease	you have, or have you	u had, any of the	following?							
Anaphylaxis	AIDS/HIV Positive	○ Yes ○ No	Cortisone Med	licine	O Yes	○ No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O
Anemia Yes No Easily Winded Yes No Herpes Yes No Rheumatic Fever Yes Order Angina Yes No Emphysema Yes No High Blood Pressure Yes No Rheumatism Yes Order Yes Order Yes No High Blood Pressure Yes No Scarlet Fever Yes Order Order Order Order Order Yes Order Yes Order Yes Order Yes Order Yes Order Or	Alzheimer's Disease	O Yes O No	Diabetes		O Yes	○ No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O
Angina	Anaphylaxis	O Yes O No	Drug Addiction	1	O Yes	○ No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O
Angina	Anemia	O Yes O No	Easily Winded		O Yes	○ No	Herpes	○ Yes ○ No	Rheumatic Fever	O Yes O
Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Yes One Artificial Heart Valve Yes No Excessive Bleeding Yes No Artificial Joint Yes No Excessive Bleeding Yes No Artificial Joint Yes No Excessive Thirst Yes No Artificial Joint Yes No Excessive Thirst Yes No Artificial Joint Yes No Fainting Spells/Dizziness Yes No Fainting Spells/Dizziness Yes No Blood Disease Yes No Brequent Cough Yes No Brequent Diarrhea Yes No Brequent Headaches Yes No Brequent Headaches Yes No Breuise Easily Yes No Genital Herpes Yes No Glaucoma Yes No Chest Pains Yes No Heart Attack/Failure Yes No Congenital Heart Disorder Yes No Heart Pacemaker Yes No Convulsions Yes No Heart Trouble/Disease Yes No Convulsions Yes No Heart Trouble/Disease Yes No Parathyroid Disease Yes No Wenereal Disease Yes No Yes No Wenereal Disease Yes No Yes No Wenereal Disease Yes No Yes	Angina	O Yes O No			O Yes	O No	COLUMN TOWNS AND ADDRESS OF THE PARTY OF THE	O Yes O No	Rheumatism	O Yes O
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Breathing Problems Yes No Genital Herpes Yes No Genital Herpes Yes No Liver Disease Yes No Stroke Yes Order Order Yes No Genital Herpes Yes No Lung Disease Yes No Thyroid Disease Yes Order Ord		The state of the s						The state of the s		
Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes Cancer Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes One Chemotherapy Yes No Chest Pains Yes No Heart Attack/Failure Yes No Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Heart Pacemaker Yes No Heart Trouble/Disease Yes No Parathyroid Disease Yes No Venereal Disease Yes One Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes One						110	Leukemia	the second secon	Stomach/Intestinal Disease	
Cancer	Breathing Problems	O Yes O No	Frequent Head	daches	O Yes	O No	Liver Disease	O Yes O No	Stroke	
Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tonsillitis Yes Osteoporosis Yes No Pain in Jaw Joints Yes No Ulcers Yes Ores Ores Ores No Heart Pacemaker Yes No Parathyroid Disease Yes No Yes Ores Ores Osteoporosis Yes No Parathyroid Disease Yes No Venereal Disease Yes Ores Ores Ores Ores Ores Ores Ores Or	Bruise Easily	O Yes O No	Genital Herpes	5	O Yes	O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O
Chest Pains	Cancer	O Yes O No	Glaucoma		Yes	○ No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O
Cold Sores/Fever Blisters O Yes O No	Chemotherapy	O Yes O No	Hay Fever		O Yes	○ No	Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O
Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Psychiatric Care Yes No Yenereal Disease Yes Yes No		○ Yes ○ No	Heart Attack/F	ailure	O Yes	○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	O Yes O
Congenital Heart Disorder		rs O Yes O No	Heart Murmur		O Yes	○ No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O
	Chest Pains		Heart Pacema	ker	O Yes	○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	O Yes O
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	Chest Pains Cold Sores/Fever Bliste Congenital Heart Disorder	○ Yes ○ No		O Yes (If yes			Yellow Jaundice	○ Yes ○



E-Mail/Text Notification Opt-in Consent Form

Dr. Delaine Daniels, DDS is in the process of offering E-Mail and Text Message notification for Appointment Reminders and other patient care related information. This system will allow you to verify appointments at a time convenient to you and to keep you informed of office and patient care information. If you choose to opt-in to this system please provide us with your email address and text messaging number below. The information is only used for Dr. Delaine Daniels, DDS purposes and is governed by the text/email addresses from our patients' parents/guardians. Your Name: Patient Name: E-Mail: Text Number: I authorize Delaine Daniels, DDS to notify me of patient care related information on my E-Mail or Text Messaging (Please circle one or both). **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES** (You may refuse to sign this acknowledgement) I, ______, have received copy of Delaine Daniels, DDS Notice of Privacy Practices. Parent/Guardian Printed Name Date Parent/ Guardian Signature Patient's Name We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgement could not be obtained for the following circled reason: Individual refused to sign. Communications barriers prohibited obtaining acknowledgement. An emergency situation prevented us from obtaining acknowledgement. Other

Date

Staff Signature