PATIENT INFORMATION **DATE_____**

NAME_____ Married__ Single__ Male__ Female__
ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____
PHONE (Home) _____ (Work)_____
PHONE (Cell) _____ E-mail_____
BIRTH DATE_____ SS#_____
How would you prefer to be reminded of appts? ___Email only ___Text only ___Phone Call
DRIVERS LICENSE NUMBER_____
PLACE OF EMPLOYMENT_____
IF FULL TIME COLLEGE STUDET, SCHOOL NAME_____
DENTAL INSURANCE COMPANY_____GROUP#_____
Has any member of your family ever been treated in our office?_____
Whom may we thank for referring you to our office?_____

_____

_____

Father (if minor)/Spouse/Partner			Mother (if minor)/Spouse/Partner			In an emergency, contact:
_____			_____			Name_____
Last	First	M	Last	First	M	
_____			_____			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

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ 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
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

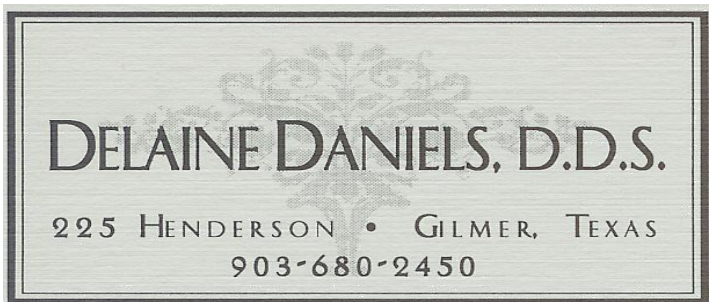
Have you ever had any serious illness not listed	◯ Yes ◯ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____



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

*****************************FOR OFFICE USE ONLY****************************

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_____

_____ _____

Staff Signature **Date**