TIME 10:33 AM DATE 9/12/2022

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency Number

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

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	
Do you use controlled substances?	○ Yes ○ No	If yes

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 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 above? ○ 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:_____

Daniels Parkway Dental

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name:_____ **Patient DOB**:_____

Please CHECK one of the following:

_____I give my permission to Daniels Parkway Dental to disclose my protected health information and patient medical record information to the following individuals (this would allow for example discussion of any treatment options, insurance coverage or payment options):

NAME:_____ RELATIONSHIP:_____ PHONE:_____

NAME:_____ RELATIONSHIP:_____PHONE:_____

NAME:_____RELATIONSHIP:_____ PHONE:_____

NAME:_____ RELATIONSHIP:_____PHONE:_____

OR

____I request that all my Protected Health Information and/or Medical Record Information be disclosed to **ME ONLY**.

May we contact you and/or leave appointment reminder information on any of the following? Please initial the device(s) acceptable:

_____Home Answering Machine/Spouse
_____Cellular Phone Voicemail
_____Work Voicemail or Answering Machine

Due to current changes in the dental insurance industry, it is becoming increasingly difficult to obtain insurance benefit specifics for individual plans. We do our best as a courtesy to our patients, but we can only give an ESTIMATE of coverage. The patient or guarantor is responsible for all treatment rendered not covered by insurance.

At any time the patient may revoke this consent through written notification to Daniels Parkway Dental.

Signature of Patient or Authorized Representative:_____ Date:_____

Printed Name of Patient or Authorized Representative:_____ Date:_____

DANIELS PARKWAY DENTAL

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign This Acknowledgment.)

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Daniels Parkway Dental this _____day of_____,20____. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
PLEASE PRINT YOUR NAME

_____
PLEASE SIGN YOUR NAME

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority:_____

Thank you and if you have any questions about this form or our Notice, please contact our privacy officer, Shelly King, D.M.D..

_____

Office Use Only As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

.

__ It was emergency treatment.
__ I could not communicate with the patient.
__ The patient refused to sign.
__ The patient was unable to sign because:_____
__ Other (please describe)_____

Signature of privacy officer_____

_____

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

DENTAL BENEFIT EXPLANATION

It is our policy to provide the best dentistry for you. To do this, it is important that we do not let dental benefits be a determining factor in the diagnosis. Your treatment will be based upon your specific needs, and we assume that you are as concerned as we are about maintaining your good health.

As a courtesy to you, we will submit claims to your dental plan carrier. We will also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion at the time the services are provided. However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We will only allow a 60 day hold on insurance payments and then we will need to bill the balance to your account. We take no responsibility for any denials by dental plans. For your convenience, we do accept Mastercard, Visa, and offer interest free financing as well. (Ask us for more information.)

I agree and understand these policies regarding my dental benefits. I also authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

_____ _____
PATIENT SIGNATURE DATE

DANIELS PARKWAY DENTAL
Dr. Bryant King D.M.D.
6900 Daniels Parkway Suite 30
Fort Myers, FL 33912
239-337-5464
office@danielsparkwaydental.com

CANCELLATION POLICY

We ask that you provide us with 24 hours notice of cancellation for any appointments.

We reserve the right to charge a $55.00 fee for any appointments that are missed without notice.

Thank You for understanding

Print Name:_____

Signature:_____

Date:_____