Jason R McDaniels DDS PLLC

First Name: ______________________

Middle Initial: ______________________

Last Name: ______________________

Address 1: ______________________

Address 2 if different than mail:

____

City: ______________________

State: ______________________

Zip: ______________________

Phone (Home): ______________________

Phone (Work): ______________________

Phone (Mobile): ______________________

Email: ______________________

SS#: ______________________

Birthdate: ______________________

Gender: ______________________

Referred by Dentist: ______________________

Your Occupation:

____

Employer: ______________________

Employer Address: ______________________

____

Emergency Contact Name & Phone #:

____

Spouse: ______________________

Person Financially responsible for bill:

____

Address: ______________________

____

If Child, Parents Name and Address:

____

____

____

Insurance

Name of Insurance Company:

____

Address: ______________________

City: ______________ State: __________

Zip: ______________________

ID #: ______________________

Group #: ______________________

Employer Name: ______________________

Phone # ______________________

Insurance Policy Holder Name:

Self ______ Spouse ______ Parent ______

____

Address: ______________________

City: ______________ State: __________

Zip: ______________________

Phone: ______________________

Gender: ______________________

SS#: ______________________

Birthdate: ______________________

HIPAA Right of Access Form for

Family Member/Friend

I, ______________________________, direct my health care and medical service providers and payers to disclose and release my protected health information described below to:

With whom may we discuss your treatment other than you physician/dentist:

Name: ______________________________ Relationship: ____________________

_____ Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billings for all conditions) OR

______ Disclose my health record, as above, But Do Not disclose the following information

_____ Mental health records

_____ Communicable disease (including HIV and AIDS)

_____ Alcohol/Drug abuse treatment

_____ Other (please specify): ________________________

Form of Disclosure: ______ electronic record (email) or access through an online portal or______ hard (paper) copy

This authorization shall be effective until (check one):

_____ All past, present and future periods,

_____ Specific Date or event: __________________

Unless I revoke it. (Note: You may revoke this authorization in writing at any time by notifying your health care provider, preferable in writing).

Signature: ____________________________________ Date: ______________

Financial Policy

I understand that if I do not have dental insurance that I am responsible for payment in full at the time of treatment. If I do have dental insurance, I am responsible for my estimated portion in full at time of treatment. Cash, credit card, personal check, and CareCredit are accepted. If an exception is made, a Truth In Lending Statement will be completed below. Jason R McDaniels DDS PLLC is NOT an In-network provider.

No warranty or guarantee of success has been or can be given in root canal treatment. I acknowledge full responsibility for the payments of such services. I agree that no refund is due if the tooth is lost prematurely or if other complications occur.

While the staff will make their best attempt to get accurate benefit information, I understand that any balances due after Insurance pays (due to: under estimation, having met insurance plan maximum for year or for procedures not covered by insurance, etc) or for account for which insurance was not paid within 60 days of treatment, that this balance is my responsibility and is due in full at the time. If any balance is not paid in 60 days of service date, the account will be turned over to collection agency.

Signature: ______________________________ Date: _____________

Medical/Dental History

Name of your Medical Physician: ______________________ Date of Last Visit: ____________

Please circle any of the following that you have or have had:

Heart Trouble	Cancer	Asthma
Rheumatic Fever	Radiation Treatment	Hives or Skin Rash
Mitral Valve Prolapse	Arthritis	Depression/Anxiety
Heart Murmur	Osteoporosis	Substance Abuse
Angina	Joint Replacement Surgery	Venereal Disease
Stroke	Liver Disease-jaundice/hepatitis	Herpes Oral (cold sore)
High Blood Pressure	Kidney Disease	Herpes Genital
Diabetes	Thyroid Condition	HIV Positive
Fainting Spells/Seizures	Ulcers	AIDS
Clenching/Grinding TMJ Disorder	Sinus Trouble	Tuberculosis
Bleeding Disorder	Environmental Allergies	Major Surgery

Please list any medications you are allergic to:

Name	Reaction	Name	Reaction

Please name all current medications, dosages, & reason for taking them:

Name	Dose	Reason	Name	Reason	Dose

Do you smoke? ____________

Women: Are you pregnant: __________

Do you have any other disease, condition, or problem not listed above? _____ Please explain

____

Dental History

1. Have you had any trouble associated with previous dental treatment (dizziness, fainting or reaction to novocaine)? Yes No
2. Do you have any lumps or sores in your mouth? Yes No
3. Are you allergic to Latex? Yes No Reaction ____________________

To the best of my knowledge, the above information is correct and complete.

Patient's Signature	Date	Reviewed	Date

What brings you to see us today?

____

____

Do you have any of the following symptoms? (Circle all that apply):

Tooth pain/Pressure   Hot/cold/sweet sensitivity   Biting   Swelling
Pain wakes you up at night   Pain getting worse

Describe pain (circle all that apply):

Sharp   Dull Ache   Lingering   Throbbing   Spontaneous   Radiating
Pulsating   Constant   On/off

When did the symptoms start? ________________________

Is there anything that makes the symptoms better or worse? _______________

Describe your pain on a scale from 0 (no pain) to 10 (worst pain ever) today?
0   1   2   3   4   5   6   7   8   9   10

Describe your pain on a scale from 0 (no pain) to 10 (worst pain ever) at its worst?
0   1   2   3   4   5   6   7   8   9   10

Are you taking any medications for the pain? __________________________

Covid-19

Have you had your COVID-19 vaccination?	Yes	No
Do you have a fever or have you felt feverish in the last 14 days?	Yes	No
Are you having any difficulty breathing?	Yes	No
Do you have a new cough?	Yes	No
Have you recently lost your sense of taste or smell?	Yes	No
Do you have other flu-like symptoms?	Yes	No
Have you been in contact with any confirmed COVID-19 positive patient?	Yes	No
Do you have any lung disease?	Yes	No

Name: ____ Date: ____________
Signature: ____