We Are Honored By Your Call For An Appointment

We wish to extend a warm welcome to you. Thank you for choosing us to contribute to your dental health and well-being. Most of our patients come to us through referrals. When we are recommended to a friend or family member, we consider it a great compliment. We value your opinion and appreciate you as a patient in our practice. We welcome any questions, concerns, or suggestions you may have about our office or our services.

The pride we take in our office is reflected in the quality of care we offer and how we treat our patients. To us these are inseparable. Quality is critically important to us because it’s not enough to say we care, we need to demonstrate our commitment. Our mission of caring directs everything in our office. Continuing education in various areas of dentistry including preventative, restorative and cosmetic serves as one way we strive at success in that mission.

In order to prevent dental disease the active disease must be evaluated and eliminated. Therefore, we must have a complete picture of your present oral conditions, as well as insight into your dental and medical history. To help us with this we ask that you take the time necessary to carefully complete the enclosed patient registration and medical history. We will take necessary x-rays to aid in a thorough dental exam and oral cancer screening.

We feel it is important to discuss our examination findings with you, make recommendations for treatment, discuss the fees involved and mutually decide on a treatment plan that best suits you and your dental health needs.

All visits are by appointment. This ensures that we are able to spend enough time with each patient to get the best possible results. If you have an emergency, please call us to make an appointment so we may prepare for your arrival. If you need to reschedule an appointment, we request that you give us a 24 hour notice, to help us accommodate another patient.

We hope you are comforted in knowing that our office strives to meet your dental needs at a high level of service. We all really enjoy what we do and feel fulfilled in providing excellent results. We hope this letter has conveyed the sense of pride with which we do our work, how important this work is to us and why we are pleased you have chosen us.

Sincerely,

P. A. Daniel, Jr., DDS
A Word to Our Patients with Insurance

During the past decade, dental benefit plans have become an integral part of healthcare planning for many families.

You or your employer purchased a specific benefit plan from the hundreds of combinations available which can vary considerably from one plan to the next. A decision was made by you or your company on the amount that was willing to be used to purchase dental benefits and a plan was chosen to meet as many of the needs as possible. The range of benefits depends on what the purchaser wishes to offer employees or members. Some plans may cover as little as 30% or as much as 100% of dental services, with most falling in the 50% to 80% range. Some plans exclude or have limitations placed on certain types of services, such as orthodontics, while others cover a full range of dental services.

Some plans base the amount of benefit on a chart or fee schedule arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage of the actual reimbursement level than indicated in your dental plan. For example, your benefit plan states that it will pay 80% of the UCR dental treatment, which is a fee determined by the insurance company, and this fee may not be the actual fee charged by our dental practice. As a courtesy to our patients we offer to submit a predetermination of benefits to clarify your portion of the fee, however, this will usually delay treatment.

The type of treatment you need and receive from our office is based on my professional judgment and cannot be dictated by the coverage of your dental plan. I do not believe it is in either of our best interests to compromise treatment in order to accommodate an insurance company’s benefit plan that may be considered less than optimal. I am more than happy to discuss advantages and disadvantages of a treatment plan with you, thereby involving you, rather than your insurance company, in your treatment decision making process.

As a courtesy to you, my staff will submit your dental claims for you. To expedite processing please carefully complete the insurance information portion of the registration form to the best of your knowledge. Also, please bring your dental insurance card with you to your appointment so we may obtain a copy for our records. Our staff is willing to assist you with insurance processing and account management. However, you retain financial obligation for services rendered to you by our practice. If you have current insurance, we will make arrangements with you on your portion (co-pay) and file your insurance. The insurance company is responsible to you, not to my office. For this reason, in the event that your insurance is delayed, does not cover a particular service, or is denied, please keep in mind that the remainder of the balance is your responsibility and is due at the time treatment is complete.

We will assist you in every way in filing your claims, responding to any questions or concerns, whether it is in regards to your treatment, benefit plan or a statement received. We are here to assist you.

Sincerely,

P. A. Daniel, Jr. DDS
P.A. DANIEL, JR., D.D.S.
2300 Wayne Memorial Drive, Suite D
Goldsboro, North Carolina 27534
Telephone 919-734-4716

Authorization for Release of Information - Compound Release

Name of Patient ________________________________ Date of Birth ________________

P.A. Daniel, Jr., D.D.S. is authorized to release protected health information about the above name patient in the following manner and to persons listed.

Entity to Receive Information. Check each person/entity that you approve to receive information.

☐ Voice Mail

☐ Spouse (provide name and phone number)

☐ Parent (provide name and phone number)

☐ Email communication - Provide email address*

Description of information to be released. Check each that can be given to person/entity on the left in the same section.

☐ Results of lab tests/x-rays

☐ Other ____________________________

☐ Financial

☐ Medical

☐ Financial

☐ Medical

☐ Financial

☐ Appointment reminders

☐ Breach notification

*In order for email communication to occur, please accept the disclosure below:

☐ For email communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

Patient Rights:
• I have the right to revoke this authorization at any time.
• I may inspect or copy that protected health information to be disclosed as described in this document.
• Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
• Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
• I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

______________________________ Date ____________________
Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)
Date: 

Patient Name: 

Patient Date of Birth: 

Patient home phone # ( ) 

Patient Address: 

Primary Insurance:
Policy Holder’s Name: 

Relationship To Patient: ___________, please list all other family members covered:
Policy Holder’s Date of Birth: Month_____ Day_____ Year_____
Street Address __________________ City________________ State_______ Zip_______
Home Phone (_____ Policy Holder’s SSN (must have)__________
Insurance Company Name: ________________________ 800#
Group #: __________________________ ID#
Place of employment insurance is offered through ____________________________________ or,
was this insurance purchased privately on your own, yes ___ no ____

****OR****

If Retired, from where __________________________ Phone# ______________________

Secondary Insurance:
Policy Holder’s Name: 

Relationship To Patient: ___________, please list all other family members covered:
Policy Holder’s Date of Birth: Month_____ Day_____ Year_____
Street Address __________________ City________________ State_______ Zip_______
Home Phone (_____ Policy Holder’s SSN (must have)__________
Insurance Company Name: ________________________ 800#
Group #: __________________________ ID#
Place of employment insurance is offered through ____________________________________ OR,
was this insurance purchased privately on your own, yes ___ no ____

****OR****

If ins. is through a place of Retirement, _________________ Phone# ______________________

Assignment and Release
I, the undersigned, certify that my dependent or I have insurance coverage with ____________________ and assign payment directly to P.A. Daniel, Jr. DDS. All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am FINANCIALLY RESPONSIBLE for all charges, whether paid by my insurance company or not. I hereby authorize Dr. P.A. Daniel, Jr. DDS to release all information necessary to secure payment of all insurance benefits. I further authorize the use of this signature on all insurance submissions.

Signature: ___________________________ Date: ______________________

Witness: ___________________________ Date: ______________________
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgment that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Carrie Wildman
P. A. Daniel, Jr., DDS
2300 Wayne Memorial Dr., Ste. D
Goldsboro, NC 27534
919-734-4716

For more information about HIPAA to file a complaint:
The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
202-619-0257 or Toll Free: 1-877-696-6775
Notice of Privacy Practices Acknowledgement

P. A. Daniel, Jr., DDS
2300 Wayne Memorial Dr., Ste. D
Goldsboro, NC 27534

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do not agree, then you are bound to abide by such restrictions.

Patient Name: ________________________________

Relationship to Patient: __________________________

Signature: ________________________________

Date: ________________________________

Office Use Only

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date_____________ Initials ________ Reason __________________________________________
P. Alston Daniel Jr., DDS Recognized for Excellence in Medicine Specialty in Dentistry

Goldboro, North Carolina, June 26, 2015 P. Alston Daniel Jr., DDS has been recognized by Trademark Who’s Who for showing dedication, leadership and excellence in Medicine specialty in Dentistry.

Dr. P.A. Daniel Jr. is Owner of Dr. P.A. Daniel DDS and has been so since 1986. He was inspired to join the dentistry field by a family member. Dr. Daniel Jr.'s degrees include; East Carolina University, Degree in BA Chemistry 1977-1981 as well as UNC Chapel Hill Dental School 1982-1986. Dr. Daniel Jr. specializes in complete restoration, complex restoration as well as cosmetic dentistry and uses high tech techniques. He has practiced solo since 1988. Along with his extensive education background, Dr. Daniel Jr. is very active in his community. He has served as a member of Westwood United Methodist Church for over 25 years and is also a past President of the Church as is also an Air Force Association Community Partner. Other accomplishments include being a UNC Dental Research Affiliate, Member ADA – 5th district, Wayne County Dental Society as well as being a member of the Four Corners Study Club. Dr. Daniel Jr. enjoys spending time with his family and watching as his daughter follows in his footsteps in becoming a future dentist. He believes that following the Golden Rule and staying strong in faith has greatly contributed to his success. With so many accomplishments and contributions to dentistry it is so fitting that Dr. P.A. Daniel Jr. has been Honored as a selected member of Trademark Who’s Who Top Doctors Honors Edition.

Dr. P. Alston Daniel Jr., DDS will join the likes of many professional men and women who also have achieved great success in the forthcoming 2014-2015 edition.

About Trademark Who’s Who
With expert members representing every specialty in medicine, Trademark Who’s Who is the trusted resource and historic tool that facilitates the creation of new business relationships in all areas of business. Following the same tradition of the now more than 100 year old concept, Trademark Who’s Who prides itself on preserving the stories of each member as each of them deserve his and her own place in history. The talented professionals profiled in the historic registry share such virtues as determination, courage, patience and discipline. It is not these characteristics which set them apart from the rest of us, but their extremely high degree of accomplishment. Now more than ever these people serve as an example, each of these extraordinary people documented in this book offer tangible evidence of the value of hard work, goal setting and passion.

Trademark Who’s Who membership provides these hardworking men and women with a certified and validated third-party endorsement of their accomplishments, and serves as a way to spread the word about themselves through a trusted network of individuals brought together by the same common morals, values, and dedication. The historic preservation of one’s family legacy and personal achievements is also a driving force in the success of this publication. Such a well-researched and verified source ensures this tool to act as a bridge forging long lasting new business relationships.

For more information please visit http://www.Trademarkwhoswho.com
Contact:
Amber Rogers
Director, Media & Public Relations
Trademark Who’s Who
(864) 603-1784
Email: Publicrelations@trademarkwhoswho.com
Dr. P.A Daniel  
Eaglesoft Medical History  
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...  
Fetal  Nursing?  Taking oral contraceptives?  

Are you allergic to any of the following?  
Aspirin  Penicillin  Codeine  Acrylic  
Metal  Latex  Sulfur 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  
Alzheimer's Disease  Yes  No  
Anaphylaxis  Yes  No  
Anemia  Yes  No  
Anxiety  Yes  No  
Arthritis/Gout  Yes  No  
Artificial Heart Valve  Yes  No  
Artificial Joint  Yes  No  
Asthma  Yes  No  
Blood Disease  Yes  No  
Blood Transfusion  Yes  No  
Breathing Problems  Yes  No  
Bruise Easily  Yes  No  
Cancer  Yes  No  
Chemotherapy  Yes  No  
Chest Pains  Yes  No  
Cold Sores/Fever Blister  Yes  No  
Congenital Heart Disorder  Yes  No  
Convulsions  Yes  No  
Cortisone Medication  Yes  No  
Diabetes  Yes  No  
Drug Addiction  Yes  No  
Easily Winded  Yes  No  
Emphysema  Yes  No  
Epilepsy or Seizures  Yes  No  
Excessive Bleeding  Yes  No  
Excessive Thirst  Yes  No  
Fainting Spells/Dizziness  Yes  No  
Frequent Cough  Yes  No  
Frequent Diarrhea  Yes  No  
Frequent Headaches  Yes  No  
Genital Herpes  Yes  No  
Glaucoma  Yes  No  
Hay Fever  Yes  No  
Heart Attack/Failure  Yes  No  
Heart Murrur  Yes  No  
Heart Pacemaker  Yes  No  
Heart Trouble/Disease  Yes  No  
Hemophilia  Yes  No  
Hepatitis A  Yes  No  
Hepatitis B or C  Yes  No  
Herpes  Yes  No  
High Blood Pressure  Yes  No  
High Cholesterol  Yes  No  
Hives or Rash  Yes  No  
Hypoglycemia  Yes  No  
Irregular Heartbeat  Yes  No  
Kidney Problems  Yes  No  
Leukemia  Yes  No  
Liver Disease  Yes  No  
Low Blood Pressure  Yes  No  
Lung Disease  Yes  No  
Mittal Valve Prolapase  Yes  No  
Osteoporosis  Yes  No  
Pain in Jaw Joint  Yes  No  
Parathyroid Disease  Yes  No  
Psychiatric Care  Yes  No  
Radiation Treatments  Yes  No  
Recent Weight Loss  Yes  No  
Renal Dialysis  Yes  No  
Rheumatic Fever  Yes  No  
Rheumatism  Yes  No  
Scarlet Fever  Yes  No  
Shingles  Yes  No  
Sickle Cell Disease  Yes  No  
Sinus Trouble  Yes  No  
Spine Bifida  Yes  No  
Stomach/Intestinal Disease  Yes  No  
Stroke  Yes  No  
Swelling of Limbs  Yes  No  
Thyroid Disease  Yes  No  
Tonsillitis  Yes  No  
Tuberculosis  Yes  No  
Tumors or Growths  Yes  No  
Ulcers  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:  

# 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:**

**Home Phone:**

**Work Phone:**

**Ext:**

**Pager:**

**Cellular:**

**Drivers Lic:**

---

[ ] Responsible Party is also a Policy Holder for Patient

[ ] Primary Insurance Policy Holder

[ ] Secondary Insurance Policy Holder

---

**Address Information**

**Address:**

**Address 2:**

**State / Zip:**

**Home Phone:**

**Work Phone:**

**Ext:**

**Cellular:**

---

**Sex:**

[ ] Male

[ ] Female

**Marital Status:**

[ ] Married

[ ] Single

[ ] Divorced

[ ] Separated

[ ] Widowed

**Birth Date:**

**Age:**

**Soc Sec:**

**Drivers Lic:**

---

[ ] 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:**

**Employer ID:**

**Carrier ID:**

**Pref. Dentist:**

**Pref. Pharmacy:**

**Pref. Hyg:**

---

**Section 3**

**Parent/Guardian Name**

---

**Primary Insurance Information**

**Name of Insured:**

**Insured Soc. Sec:**

**Insured Birth Date:**

**Employer:**

**Address:**

**Address 2:**

**City, State, Zip:**

**Rem. Benefits:**

**Rem. Deduct:**

**Ins. Company:**

**Address:**

**Address 2:**

**City, State, Zip:**

---

**Secondary Insurance Information**

**Name of Insured:**

**Insured Soc. Sec:**

**Insured Birth Date:**

**Employer:**

**Address:**

**Address 2:**

**City, State, Zip:**

**Rem. Benefits:**

**Rem. Deduct:**

**Ins. Company:**

**Address:**

**Address 2:**

**City, State, Zip:**

---

**Relationship to Insured:**

[ ] Self

[ ] Spouse

[ ] Child

[ ] Other