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.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
❒ Voice Mail	❒ Results of lab tests/x-rays Other _____
❒ Spouse (provide name and phone number) _____	❒ Financial ❒ Medical
❒ Parent (provide name and phone number) _____	❒ Financial ❒ Medical
❒ Email communication - Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	❒ Financial ❒ Medical ❒ Appointment reminders ❒ Breach notification
❒ 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)

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

Date: _____

Patient Name:_____
Last First MI

Patient Date of Birth:_____

Patient home phone # (___)_____Patient Address:_____
_____
_____

Primary Insurance:
Policy Holder's Name:_____
Last First MI

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:_____
Last First MI

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 HIPPA 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 _____

_____

TRADEMARK WHO'S WHO

32 Pine Knoll Drive, Greenville South Carolina 29609

PRESS RELEASE

Who's Who in the news
Top Doctors Honors Edition
For immediate release 9:00AM May June 26, 2015

P. Alston Daniel Jr., DDS Recognized for Excellence in Medicine Specialty in Dentistry

Goldsboro, 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

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:_____

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

Parent/Guardian Name

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: