Kim N. Le D.D.S.
Cosmetic, Restorative & Implant Dentistry
990 US Highway 287 North, Ste 112
Mansfield, Texas 76063
Telephone: 817-473-6677

Today's Date: ______________________ DOB: _____________________ Patient Social Security #____________________________________

Patients Name____
(Last) (First) (Middle Initial) (Preferred)

Address____

City____State______________________Zip___________________________

Drivers License # _______________________________ Male Female Single Married Child Other _________________

Home Phone #___________________________Work Phone #_____________________________Other #______________________________

Email address____

Best form of communication: I prefer ☐email ☐text ☐phone call

Employer____Occupation______________________________________

Employer Address____

In Case of Emergency Contact:

Name____Relationship______________________________________

Address____ Contact #____

Who may we thank for referring you? ____

Account Information:

Individual Responsible for this account ____
(Last) (First)

Relationship to patient ______________________________ DOB: _________________Social Security #______________________________

Address____

City____State_______________________Zip___________________________

Employer____ Group #_______________________________________

Insurance Carrier ____Customer Service #_______________________________________

Claims Mailing Address ____

City____State___________________________Zip___________________________

Any additional Insurance coverage:

Relationship to patient ______________________________DOB: ____________________Social Security #____________________________

Employer ____ Group #_______________________________________

Insurance Carrier____ Customer Service #_______________________________________

Claims Mailing Address____

City____State__________________________Zip___________________________

Authorization to pay benefits to dentist

I hereby authorize payment directly to the above dentist for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

Terms and conditions

Undersigned hereby authorizes Dr Kim Le to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Kim Le to make a thorough diagnosis of patient's dental needs. I also authorize Dr. Kim Le to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that doctor Dr. Kim Le choose and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility of payment for dentist services provided in the office for myself or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made. I further understand that in the event of default I promise to pay legal interest on the indebtedness.

____ ___________________________________
Patient/Guardian Signature Date

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HEALTH HISTORY

Patient Name________________________ DOB: ____________
Physicians' Name ________________________ Phone #____________
Physicians Address ____________________City__________Zip__________

MEDICAL

1. Are you in good health? ________________ YES NO
2. Has there been any change in your general health within the past year? ________ YES NO
3. Date of last physical examination? ________________
4. Are you now under the care of a physician?________________ YES NO
   If so what condition? ________________
5. Have you ever had any serious illness, operation, or hospitalization? ________ YES NO
6. Are you taking any drugs or medication? ________________ YES NO
7. List type amount and frequency if so________________
8. Are you using any recreational drugs? ________________ YES NO
9. Are you taking any over the counter drugs?________________ YES NO
10. Are you sensitive or allergic to any medication? ________________ YES NO
   Penicillin Sulfa Codeine/other Narcotic Aspirin Barbiturates Iodine other __________
11. Do you have or have you had any of the following: (Please check known conditions)

Aids or HIV	Rheumatic Fever	Arthritis	Diabetes
Anemia	Blood Diseases__________	Head Injuries	Epilepsy
Artificial Joints	Sinus Trouble	Stomach Ulcers	Stroke
Heart Ailments	Sickle Cell Anemia	Venereal Disease	Heart Murmur
High Blood Pressure	Kidney Disease	Mental Disorders	Respiratory Disease
Tumors/Growths	Tuberculosis	Radiation treatment	Asthma/Hay Fever
Nervous Disorders	Allergies__________	Glaucoma	None of the above
Excessive Bleeding	Fainting Spells/ Seizures	Hepatitis, Jaundice or liver disease	
		Other__________	

If you checked yes to any of the above conditions, please give a brief explanation:
____
____

12. Do you use tobacco now or in the past?________________ YES NO
13. Do you wear a cardiac pacemaker?________________ YES NO
14. Have you had Heart surgery? ________________ YES NO
15. Do you have any disease or condition or problem not list above that you think I should know about? YES NO
   If yes, what is it? ________________
16. If you are Women, are you pregnant or nursing? If so, how many months? ________________

DENTAL

1. Previous Dentist________________City__________State________Zip________
2. Was your pattern of visits ☐regular ☐infrequent ☐sporadic Date of Last Dental Visit__________
3. Have you been having any specific problems?________________ YES NO
   Explain________________
4. Have you ever been pre-medicated with antibiotics (i.e. Penicillin, etc.) before dental treatment?
   ________________ YES NO
5. Does dental treatment make you nervous? ________________ YES NO
6. Do you have or have you had any of the following: (Please check known conditions)
   Bad Breath Loosening of teeth Bleeding gums
   Cold sores Clench your teeth
   Sensitive Teeth at . . . . Night Day Sweet Temperature
   Grind your teeth at. . . . . Night Day Hurt Lock Jaw Pop
7. Have you ever had any serious trouble associated with any previous dental treatment?
   ________________ YES NO
8. Have you ever had any of the following:
   Injury Oral Surgery Orthodontics Periodontics
9. Is there anything about the appearance of your teeth you have ever wanted to change?
   Explain________________
   ____

____
Patient/Guardian Signature Date Doctor Signature

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NOTICE OF PRIVACY PRACTICES
(DENTAL)

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

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) 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 you 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 you insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment 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 witting 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 reasonably 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 obtain a paper copy of this notice from us upon request.

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

This notice is effective as of April 14, 2003 and we are required to abide by the terms of this 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 written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, retaliate against you for filling a complaint.

- For Information about HIPAA or to file a Complaint: The U.S. Department of Health & Human Services Office of Civil Rights – 200 Independence Avenue, S.W. Washington, D.C. 20201 – (202)619-0257 – Toll Free : 1-877-696-6775

Patient Consent Form

You May Refuse to Sign This Acknowledgement

I understand that, under the Health Insurance Portability & 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 have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

______________________________________ __________________

Patient Name **Date**

____

Signature

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Right to Revoke

You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this Consent.

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

____________________________________ __________________________
Signature **Date**

OFFICE USE ONLY

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[] Individual refused to sign

[] Communications barriers prohibited obtaining the acknowledgement

[] An emergency situation prevented us from obtaining acknowledgement

[] Other (Please Specify)

____
____
____
____
____
____

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OFFICE POLICIES

It is your responsibility to keep all appointments. If you cannot keep your scheduled appointment time, in consideration of other patients in need of treatment, we kindly ask that you give the office a 24 hour advance notice, so that we may offer your reserved time to another patient who is in need of our care. **Missed appointments or appointments cancelled without a 24 hour advance notice are subject to a $50.00 charge.** Initial______________

Payments are due at the time of visit. This includes all Co-pay's, co-insurance, and deductible amounts, for your convenience we accept Cash, Check, Visa, and MasterCard.

Return checks "any bad check can and will be turned over to the justice of the peace if the account is not reconciled within 20 days." You will also be responsible for a returned check fee in the amount of $25.

If a minor is brought in for treatment, the adult seeking the treatment is responsible for payment, regardless of who carries the insurance policy or who has custody.

INSURANCE POLICIES

We participate in several dental plans. It is *your responsibility* to verify that we do participate on your plan. It is also your responsibility to know the terms, limitations, and benefits of your plan.

If we file insurance on your behalf, we need a copy of your current insurance card; you are required by your insurance company to pay all co- pay's, coinsurance, and deductibles which are due and payable at the time of service.

Verification of your insurance does not guarantee payment. Payment is subject to review by your insurance company. Payment is determined upon the actual receipt of the claims by the insurance company. If your insurance denies payment for services, you will be billed and it is your responsibility to pay for the service within 45 days of the date of treatment. It is your responsibility to contact your insurance company to dispute any denial, or nonpayment issues.

We will be happy to assist you in preparing forms or printing receipts for you to file with your insurance company.

I, the insured/dependant, have read the above and understand the policies regarding office and insurance policies. I agree to comply with all policies and agree to be responsible for payment of all services provided.

____ ____________________

PATIENT/GUARDIAN SIGNATURE **DATE**

FINANCIAL AGREEMENT

I, _____________________, understand that any service performed for my dependant or me by Dr. Kim Le or her office is my personal financial responsibility. If I have dental insurance I understand that it is not Dr. Kim Le office responsibility to collect from my insurance company.

Dr. Kim Le office will file an initial insurance claim on my behalf as a service to me at no additional cost. If my insurance carrier has not responded within 45 days of the date of the service the entire fee for the service is due and payable by me. I understand any remaining balance regardless of the amount of the insurance payment is my responsibility.

____ ____________________

PATIENT/GUARDIAN SIGNATURE **DATE**

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DENTAL PRACTICE AGREEMENT

1. Health Information
I agree to disclose all previous illnesses and medical history. Undisclosed medical information and current medication, allergies or illness are risk factors.

2. Drugs, latex and Medicines
I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases heart beat and, depending on my health, may be dangerous for me.

3. Needle Stick
If someone is inadvertently stuck with a needle used on me, I consent to have blood drawn for analysis.

4. Filings, Crowns and un-anticipated Root Canals
Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.

5. Root Canals can fail
Root Canals can fail and may require additional treatment or I may end up having to the tooth extracted.

6. Porcelain crowns, veneers, bonding and cosmetic fillings
Porcelain crowns, veneers, cosmetic bonding and composite fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed.

7. Gum Treatment and Requesting "Just a Cleaning"
If I don't floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply just need to get a cleaning (prophylaxis).

8. Extractions and Surgery
I understand that all dental extractions or surgeries carry risks. Some are minor like a dry socket following an extraction. Some are life threatening such as post surgical infection or anaphylaxis.

9. Fee for Additional or Specialty Care
I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for the additional or specialty care.

10. Limitations of Insurance Coverage
There are charges beyond what insurance will pay, e.g. nitrous oxide, temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what insurance does not cover.

11. 24 Hour notice of cancellation
I agree to give 24 hour notice for cancellations or pay the broken appointment fee. I understand that leaving a message after the office is closed the day (or weekend) before is not sufficient notice.

12. Requesting Record Transfers
Professional courtesies are between dentists. I agree not to requests records until I have a new dentist.

13. Hygiene Appointments
If I am more that 15 minutes late for my cleaning appointment, I will either take my remaining time only or reschedule and pay a broken appointment fee.

I do not expect guarantees in dental care. I have read the above and consent to agreement.

________________________________ ____________________
PATIENT / GUARDIAN SIGNATURE DATE