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

Patient Information

Date: _____ Patient Name: _____
First MI Last (Preferred Name)

Gender: Male or Female Family Status: Single Married Child Other

Social Security #: _____ Date of Birth: _____

Email: _____

Responsible Party: _____
First Last Address (if different from below)

Home Phone: _____ Mobile: _____ Work: _____

Address: _____
Street Apartment #

City: _____ State: _____ Zip Code: _____

In case of emergency: _____ _____
Name phone number

How did you hear about our office? _____

Insurance Information

Primary Insurance
Name of Policyholder: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer: _____

Patient's relationship to insured: Self Spouse Child Other _____

If you have a Secondary Insurance: Our office will be happy to help you file your insurance; however, the insurance payment from the insurance will be paid directly to you.

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.
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Patient, Parent or Guardian Signature Date

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

Health Information

Patient's Name: _____ DOB: _____ Address: _____

Cell #: _____ Email: _____ Reason for visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies: _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Bruises easily
- ☐ Cancer
- ☐ Chemo
- ☐ Codeine Allergy
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Iodine Allergy
- ☐ Jaundice
- Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Pregnancy
  Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ OTHER: _____ _____ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have a cardiac pacemaker? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you had Heart Surgery? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever been pre-medicated with antibiotics before dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Please list any medications you are currently taking, including over the counter

_____

_____ _____ _____

Patient, Parent or Guardian Signature Date Doctor's Signature

Kim Le DDS

Acknowledgement of Receipt
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I give permission for the use and disclosure of my health information as set forth above.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

Witness Signature

Date Time