IMAGE DENTAL

5510 Abrams Road • Suite 104 • Dallas, Texas 75214 214-363-1415 • fax 214-363-2881 • www.imagedental.com

TUAN TRAN, DDS

1 ABOUT YOU

Today's Date: _____

Patient Name: _____
LAST FIRST MI

What Do You Prefer To Be Called?: _____ ❑ Male ❑ Female

Birthdate: _____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext.: _____

Other Phone #s: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How long?: _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do You Have Kids?: ❑ Yes ❑ No How many?: _____

2 INSURANCE INFO

Primary Dental Insurance

Company Name: _____

Address: _____

_____
CITY STATE ZIP

Insurance Co. Phone #: _____

Insured's SS #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: _____

Insured's Employer: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____
LAST FIRST MI

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Driver's License #: _____

Work Phone #: _____

Payment Method: ❑ Cash ❑ Check ❑ Credit Card

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office).
INITIALS

4 IN EVENT OF EMERGENCY

Who should we contact?: _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor?: _____

M.D.'s Phone #: _____

PLEASE CONTINUE ON BACK

5 DENTAL INFO

Reason for today's visit: ❑ Initial Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How long? _____

Please indicate any of the following problems:

❑ Discomfort, clicking or popping in jaw ❑ Lost / Broken Filling(s)

❑ Red, swollen or bleeding gums ❑ Stained teeth

❑ Sensitive tooth, teeth or gums ❑ Bad breath

❑ Broken / Chipped tooth

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____
NAME PHONE #

Last Dental exam: _____ Last Dental X-rays: _____

Would you like whiter teeth? _____

If you could change anything about your smile, what would it be? _____

_____

6 MEDICAL HISTORY

Do you have or ever had any of the following diseases or medical conditions?:

Y N Heart Attack/Stroke	Y N Kidney Problems	Y N Cancer/Tumors	Y N Chemotherapy
Y N Heart Surg./Pacemaker	Y N Liver Problems	Y N Shingles	Y N Asthma
Y N Heart Murmur	Y N Respiratory Problems	Y N Hepatitis	Y N Difficulty Breathing
Y N Rheumatic Fever	Y N Sinus Problems	Y N HIV + AIDS/ARC	Y N Diabetes/Hypoglycemia
Y N Mitral Valve Prolapse	Y N Stomach Problems/Ulcer	Y N Arthritis/Rheumatism	Y N Leukemia
Y N Artificial Valves	Y N Psychiatric Care	Y N Artificial Bones/Joint	Y N Anemia
Y N Heart Disease	Y N Venereal Disease	Y N Emphysema	Y N High/Low Blood Pressure
Y N Congenital Heart Defect	Y N Alcohol/Drug Abuse	Y N Fainting/Seizures/Epilepsy	Y N Bleeding Problems
Y N Chest Pains	Y N Tuberculosis (TB)	Y N Severe Headaches	Y N Glaucoma
Y N Scarlet Fever	Y N Jaw Problems (TMJ)	Y N Frequent Neck Pain	Y N Back Problems

Please list any other medical condition(s) you have or ever had: _____

_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what? _____

Are you taking any medications at this time? _____ If so, what? _____

Are you under the care of a physician? _____ If so, for what condition? _____

For Women: Are you taking Birth Control pills? ❑ Yes ❑ No

Are you pregnant? ❑ No ❑ Yes / How long? _____ Are you nursing? ❑ Yes ❑ No

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 30 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Date:** _____

❑ ADULT PATIENT ❑ PARENT OR GUARDIAN ❑ SPOUSE

UPDATE
(OFFICE USE)

Initials _____ Date _____
Comments _____

Initials _____ Date _____
Comments _____

Initials _____ Date _____
Comments _____

IMAGE DENTAL

Welcome to our practice! Please take a few moments to review the following information regarding our financial policies. These policies have been established to assure the financial resources needed to provide high-quality patient care.

Charges for dental services are due and payable at the time of service. We accept cash, check, debit card, Visa, MasterCard, American Express, Discover, and CareCredit.

For patients with dental insurance:

If you have dental insurance benefits, please bring a copy of your current insurance card with you to your first appointment. If we participate with your dental insurance plan, we will submit your dental claim for you as a courtesy and accept assignment of benefits to receive payment directly from your insurance company. We expect payment of your estimated patient portion at the time of service. If a payment from your insurance company results in a credit balance or an unpaid balance, a refund or invoice will be sent to you promptly.

- The amount of insurance coverage is an estimate only and may not reflect what your insurance carrier will actually pay. Final determination will be made by the insurance company once the claim has been processed.
- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- Not every service is a covered benefit with all insurance contracts. Some insurance companies are selective in what services they cover.
- Waiting periods, copayments, deductibles, exclusions, and contract limitations may be present in your dental insurance plan. You, as the insurance subscriber, are responsible to know of any such exclusion. We encourage you to contact your insurance company directly to understand your dental insurance benefits.
- Services cannot be provided on the assumption that the charges will be paid by the insurance company. **You, as the patient, are ultimately responsible for the complete cost of your dental treatment, regardless of insurance coverage.**

Cancellation/Failure Policy: Should you need to cancel or reschedule your appointment please contact us at least 24 hours prior to the scheduled appointment. A fee of $50 may be charged if an appointment is cancelled or missed with less than 24 hours' notice.

Senior Courtesy: For uninsured patients over 65, we offer a 10% courtesy for payment in full by cash or check at the time of service. This cannot be combined with the prepayment courtesy or utilized with insurance benefits.

Prepayment courtesy: For patients who are uninsured and not utilizing the senior courtesy policy, we offer a 5% prepayment courtesy for prepayment of qualified treatment plans **in full** by cash or check **before** the services are rendered. This only applies for treatment plans over $1,200.

Addition Charges: Any check return from the bank for "insufficient funds" will result in a $40.00 charge on your account. If a check is returned for insufficient funds, it may be re-presented electronically to your bank, and you will be assessed an additional processing fee of $20-30 or maximum amount allowed by law. The check writer is also responsible for other check recovery costs including all attorney fees, court costs, and taxes. If your account is turned over to a collection agency for failure to abide by the terms listed above, you will be responsible for all collection fees, attorney fees, and court cost. A billing charge of 1.5% *per month will be assessed on accounts that are not paid in full within 30 days of billing.*

I understand that I am financially responsible for the entire amount of my dental services. Payment is due at the time of service unless other financial arrangements have been documented in my chart. When applicable, a claim will be filed with my insurance company. I hereby assign my payable insurance benefits to Image Dental for application to my bill. I am responsible to pay any amount that the insurance does not pay. I authorize the release of any information necessary to process my insurance claim.

Signature: _____ Date: _____

Printed Name: _____ Witness: _____

IMAGE DENTAL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect Monday, April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event

of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $30.00 to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

IMAGE DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain 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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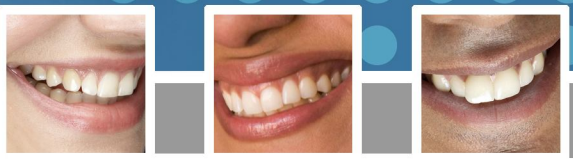

Consent for Internet Communications

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

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____