AUBREY FAMILY DENTAL

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Work Phone_____ Text & Email Notifications? YES/ NO

Date of Birth_____ Age_____ Driver's License #_____

Email_____ Soc. Sec #_____

How did you hear about us? (Check all that apply)

Internet__ Insurance__ Post card__ Drive By ____Family/ Friend___

Emergency contact_____ Phone_____

By signing below, I authorize AUBREY FAMILY DENTAL to share my medical information with the contact listed above. Patient signature:_____

If patient is under 18 years old:

Parent/Guardian_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Work Phone_____ Text & Email Notifications? YES/ NO

E-mail_____

Soc. Sec. #_____ Date of Birth_____

I acknowledge that I have read and / or received a copy of Aubrey Family Dental's Notice of Privacy Practices.
Patient Name or Patient's Representative: _____

Signature: _____ Date _____

MEDICAL HISTORY

Patient Name_____ Date of birth:_____

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, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ◯ 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

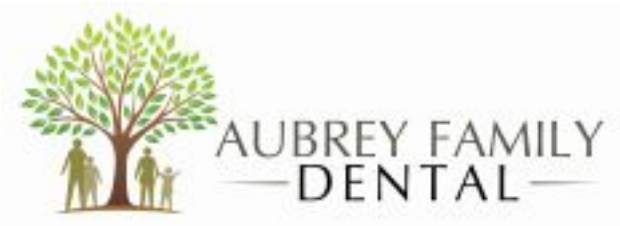
Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 _____ DATE _____



To My Appreciated Patient,

I have a purpose – and that purpose is to get sick people well and to prevent the well from getting sick. I also have a personal, professional, and ethical responsibility to care for your health to the best of my ability.

In order to do this, the following policies must be agreed upon:

_____No-shows are not acceptable. Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) **you are expected to call within 48 hours of your appointment to reschedule**. There is a $100.00 fee for all no-show appointments and this fee is not covered by insurance. This money will be matched by Aubrey Family Dental and donated to the North Texas Food Bank, and Dominican Dental Project, Inc.

_____We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.

_____If you miss an appointment, we strongly encourage you to make it up. It is critical to your health to do so to avoid setbacks in the care and maintenance of your teeth and gums.

_____Emergencies: It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we want you to be assured that we will take care of you. In order to do this we would like to define what a true emergency is. Swelling, bleeding, severe pain that has kept you up at night or requires medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these
symptoms we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergencies.

I greatly appreciate your cooperation.

Yours in Health,
Dr. Tran

_____
(Patient Signature)

Office Financial Policy:

Treatment recommendations are based on your health not on your insurance or lack thereof.

All prices presented on treatment plans are good for 90 days. After this time you will be asked to return to the office for an exam to determine if your treatment plan has changed.

In order to schedule an appointment with Dr. Tran, we require 50% of the total patient out-of-pocket expense as a deposit. We accept Master Card, Visa, Discover, American Express, Care Credit and Lending Club.

Full payment is required at the time services are rendered.

By signing, I agree to follow this policy to receive services at AUBREY FAMILY DENTAL:

_____ Date: _____

Insurance Agreement:

If you have insurance it is your responsibility to be aware of what your benefits are. Remember, insurance companies are not concerned about your health or well-being – we are. We will provide you with an **ESTIMATE** of benefits; however **you are fully responsible for any treatment performed.** Your benefits are a contract between you and your insurance company. Should your insurance company down-code, bundle your fees or not cover as we estimated, you are responsible for paying the fee. We cannot be responsible for what your insurance will or will not cover.

If you intend to use insurance, please review the following and initial by the statements:

_____I understand that if insurance does not pay for any services rendered, that I will be responsible for the remaining balance.

_____ I understand that if I agree to a service that is not covered by my dental insurance, I must pay the office's full service fee for the service.

_____ I understand that the treatment plans given to me are an estimate based on information that has been given to the office, and any information insurance gives, must be given to the office directly before any changes can be made.

_____ I understand that I have the right to request a pre-determination be sent to my insurance before any services are performed.

_____ I understand that by requesting a predetermination that it may take up to 5 months for the office to receive a response, that insurance still does not guarantee payment, and the treatment diagnosed may change while waiting for a predetermination.

I have read and agree to all the statements above:

Signature:_____ Date:_____

We want all of our patients to be healthy and remain so. Because of this, we have staff members that are here to help explain and answer any questions you may have.

Smile Evaluation:

Do you like the way your teeth look? Yes ( ) No ( )

Would you like for your teeth to be whiter? Yes ( ) No ( )

Would you like to discuss whitening options? Yes ( ) No ()

Would you like your teeth to be straighter? Yes ( ) No ( )

Would you like to discuss straightening options? Yes ( ) No ( )

Do you like the shape of your teeth? Yes ( ) No ( )

Would you like to discuss cosmetic options? Yes ( ) No ( )

Do you clench or grind your teeth? Yes ( ) No ( )

Do you have a nightguard? Yes ( ) No ( )

Is there anything specific you would like to discuss with the doctor?

NOTICE OF PRIVACY PRACTICES

Caroline Tran, DDS
5099 S US Hwy 377 Ste. 300
(940)365-3326 Office
(940)365-3396 FAX
info@aubreyfamilydental.com

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are: when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else; disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

uses or disclosures for health related research;

uses and disclosures to prevent a serious threat to health or safety;

uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

disclosures of de-identified information;

disclosures relating to worker's compensation programs;

disclosures of a "limited data set" for research, public health, or health care operations;

incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

I acknowledge that I have read and / or received a copy of Aubrey Family Dental's Notice of Privacy Practices.

Patient Name or Patient's Representative: _____

Signature: _____ Date: _____