Mai Dentist
COSMETIC AND FAMILY DENTISTRY
Vi Truong-Mai, DDS, FAGD

Phone: (972) 530-0552
Fax: (972) 530-9824
Email: Maidentist@aol.com
www.Maidentalcare.com

PATIENT CONSENT FORM FOR HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protested health information to carry out:

1) Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment).
2) Obtaining payment from third party payers (e.g. my insurance company).
3) The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right of review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Print Parent/Guardian Name: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____

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Dear Patient,

It is important to understand that this is a private practice. I am committed to providing you with the best possible care, and as such, this office continues to operate on the fees charged for **DENTAL SERVICES**. It must be noted that all patients are ultimately responsible for all fees charged. Your clear understanding of our financial policy is important to our professional relationship.

INSURANCE

For those patients who have **DENTAL** insurance, it is important to understand that actual benefit coverage varies depending on the individual insurance policy. The amount of the fees not covered by the insurance company is known as the **Co-payment.** **All Co-payments are expected at the time of service.**

As a courtesy, we will be happy to help you determine coverage you have available. We estimate as closely as possible your co-payments; however, your insurance is a contract between you and your insurance company. We, therefore, cannot guarantee payment of your claims or accept the responsibility of negotiating claims with insurance companies or other persons. If your insurance company pays only a portion of the bill or rejects your claim, you are responsible for full payment for services rendered.

Payment in full is expected at the time of service for those patients who do not have insurance. We accept cash, checks, Visa, Master Card, Discover and we have outside financing available including 90-day interest free plans with **Approved credit.** **For outstanding balance, account paid with credit card, you authorized us to use the card for the remaining balance.**

If your account requires collection by a third party, then you are responsible for all collection fees charged in addition to your delinquent balance.

MISSED APPOINMENTS

Unless canceled at least 24 hours, in advance, our policy is to charge for missed appointments, at our normal hourly office visit rate. Please help us serve you better by keeping scheduled appointments.

EMERGENCY VISITS

If you call outside of office hours, please leave your name, phone number and a brief message. A staff member monitors our answering machine regularly and if you have an emergency, the doctor will be in contact with you as soon as possible. There is a fee for emergency, after hour visits.

We realize that quality **Dental** care is expensive. **We are here to work with you. Please work with us.**

Responsible party signature _____ Date _____

VI H. TRUONG-MAI, DDS, FAGD

DENTAL TREATMENT CONSENT FORM

Patient Name: _____

1. Health Information

I agree to disclose all previous illnesses and medical and dental history (i.e. gum disease). **UNDISCLOSED MEDICAL INFORMATION—past surgeries, current medication, allergies are risk factors.** I agree to allow the use of my information only where it is necessary to process insurance claims.

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 to me.

3. Needle Stick

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

4. Fillings, 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 the tooth extracted.

6. Porcelain Crowns, Veneers, Bonding and Cosmetic Fillings

Porcelain crowns, veneers, bonding and cosmetic 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 get a cleaning (prophylaxis).**

8. Extractions and Surgery

I understand that all dental extractions or surgeries carry risks. Some are minor liked 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. I agree to pay what Insurance does not cover

There are charges beyond what insurance will pay, i.e. nitrous oxide, temporary dentures, tapping off old 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 for 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 or Copies

Professional courtesies are between dentists. I agree not to requests records **until** I have a new dentist.

[Texas State Law allows the dentist to charge up to $25 for the first 20 pages and additional fees for x-rays]

13. Hygiene Appointments

If I am more than 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 treatment.

_____ _____ _____

Signature of Patient Date Parent of Minor

Time 8:46 AM

Vi Truong-Mai,DDS,FAGD

Date 5/13/2020

Eaglesoft Medical History EDITED

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	
Do you use controlled substances?	◯ Yes ◯ No	If yes

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 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	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	Blood Transfusion	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ 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	Heart Trouble/Disease	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No				

Have you ever had any serious illness not listed above? ◯ 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.

Vi Truong-Mai, D.D.S.

Date _____

Patient Information

The information requested below will allow us to correctly establish and/or update your account. We appreciate your help in making this information as accurate and complete as possible.

Please Print:

1. PATIENT

Name _____ Birthdate _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ ☐ Male ☐ Female

Cell Phone _____ Email _____

(If patient is a child, please go next to Section 3.)

Employed By _____

Address _____ Phone _____

_____ Position _____

Drivers License # _____ Social Security # _____

(If you are single, please go next to Section 4.)

2. SPOUSE

Name _____ Birthdate _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ ☐ Male ☐ Female

Employed By _____

Address _____ Phone _____

_____ Position _____

3. MINORS ONLY

Name of Father _____	Name of Mother _____
Address _____	Address _____
_____	_____
Birthdate _____	Birthdate _____
Phone _____	Phone _____
Employed By _____	Employed By _____
Address _____	Address _____
_____	_____
Work Phone _____	Work Phone _____
DL # _____	DL # _____
SS # _____	SS # _____

4. In the event of an emergency, please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

TURN OVER →

5. Person Responsible for Account _____

   Address if Different _____

6. Nearest Relative or Friend not living with you _____ Phone _____

7. Do you have **Dental Insurance?** ☐ Yes ☐ No

   If Yes, complete the following:

	Primary Insurance	Secondary Insurance
Person Policy Issued to		
Relationship to Patient		
Social Security #		
Name of Insurance Co.....		
Insurance Company Address: Street		
City, State, Zip Code		
Group #		
Policy # / Identification #.....		
Birthdate.....		
Date Employed.....		

We need the above information so that we can help you obtain the dental insurance benefits you are eligible for. This may require submitting the Doctor's treatment plan to the insurance company(s) for a "pre-determination" of benefits or in some cases obtaining the information by phone. We can NEVER guarantee payment by your insurance company. The insurance company's contract is with you and your employer.

LET'S GET ACQUAINTED

Whom may we thank for referring you to our office?

To help your doctor know you a little better you may provide the following optional information:

What are your special interests and/or hobbies?

How long have you lived in the area?

Authorization and Release

I authorize the dentist and the staff to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent if minor)

Doctor's Comments _____