Rana Lee, D.D.S., P.A.

GENTLE DENTISTRY FOR ALL AGES

GET ACQUAINTED QUESTIONNAIRE

In order for us to serve you better, please fill in the following information. (Complete both sides).

Patients's Name_____ Date of birth_____
MARRIED SINGLE MALE FEMALE

If a Child, _____ Date of birth_____
NAME OF PERSON WHO IS RESPONSIBLE FOR THE ACCOUNT

Driver's license number__ _____ Social security number _____

Residence (Street) _____ City_____ State_____ Zip Code_____

Home Phone _____Cell Phone _____ Email_____

Emergency Contact_____Relationship_____Phone _____

Employed by _____ Present Position _____

Business Address _____ Phone _____

Name of Spouse _____Date of birth_____

Spouse Employed by _____ Present Position _____

Whom may we thank for referring you to our office? _____

HEALTH HISTORY

Circle any of the following which you have had or have at present:

HEART
heart failure
heart disease or attack
angina
pectoris
high blood pressure
rheumatic fever
congenital heart lesions
scarlet fever
artificial heart valve
pacemaker / defibrillator
heart surgery
mitral valve prolapse
ARTIFICIAL JOINT
STROKE
KIDNEY TROUBLE
ULCERS
EMPHYSEMA
TUBERCULOSIS
ASTHMA
DIABETES
THYROID DISEASE
CHEMOTHERAPY
CANCER or TUMOR HISTORY
HERPES
CORTISONE MEDICINE
(or other steroids)
GLAUCOMA
PAIN IN JAW JOINTS (TMJ)
AIDS / HIV
HEPATITIS A (infectious)
HEPATITIS B (serum)
HEPATITIS C
LIVER DISEASE
YELLOW JAUNDICE
BLOOD TRANSFUSION
DRUG ADDICTION
HEMOPHILIA
VD (syph, gon)
EPILEPSY
SEIZURES
FAINTING
DIZZY SPELLS
PSYCHIATRIC TREATMENT
DO YOU USE TOBACCO?_____

Please circle only if the answer is yes.

Yes Have you been a patient in the hospital during the past 2 years?
If yes, what for_____
Yes Have you been under the care of a medical doctor during the past 2 years?
Physician's name _____
Yes Are you currently taking any drugs or medications?
Please list _____
Yes Following injuries, medical, or dental treatment have you ever had a bleeding problem?
Yes Have you become ill or shown allergy to or been told not to take any of the following?
Please circle: Penicillin (or other antibiotic) Latex
Codeine
Novocaine or other dental anesthetic
Yes Do you have any other allergies? _____
Yes Do you have any disease, condition or problem not listed that we should know about? _____

WOMEN

Yes Are you pregnant? Due date? _____
Yes Are you taking birth control medications?

INFORMED CONSENT

I certify that the answers to the health questions are correct. Since a change of medical condition or medication can affect dental treatment, I understand the importance of and agree to notify the doctor of any changes at any subsequent appointment. I give my consent for the dental treatment that the doctor indicates on the examination chart and any other dental treatment deemed necessary or advisable as a corollary to the planned dental treatment. I also agree to the use of a local anesthetic, as needed.

If patient is a minor, I hereby grant permission for dental treatment to be performed on this minor and will assume all responsibilities connected with such treatment.

X_____ X_____
Doctor's signature Date Signature Date

SMILE EVALUATION

Is there anything about your smile you don't like? _____

Do you like the appearance of your teeth? _____

Are your teeth all in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable for chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental work that you don't like? _____

What would you like to change the most in the appearance of your teeth? _____

Are you aware of the new techniques in dentistry? _____

DENTAL HISTORY

Are you nervous about dental treatment? _____

Is there anything about your mouth that concerns you now? _____

How long has it been since you have seen a dentist? _____

What type of toothbrush do you use? ☐ Soft ☐ Medium ☐ Hard

Do you use dental floss, toothpicks? _____ How often? _____

When was your last dental appointment? _____ X-rays? _____

Last date you had your teeth cleaned? _____

Do your gums ever bleed? _____ How often? _____

Are any of your teeth mobile? _____

Do you have any swelling, sores or blisters in your mouth? _____

Have you ever been instructed in how to prevent tooth decay? _____

Have you ever been told that you have gum disease? _____

Do you smoke? _____ Chew Tobacco? _____

Do you feel you have unpleasant breath at times? _____

How would you describe your dental health? _____

REMARKS

_____

_____

_____

_____

_____

Rana Lee, D.D.S., P.A.
GENTLE DENTISTRY FOR ALL AGES

Rana Lee, D.D.S., P.A.
2204 W. Shady Grove
Irving, TX 75060

Office Policy

So that the office can better serve you, we find it necessary to have all patients read and understand our office policy. If you have any questions please feel free to ask the staff.

BROKEN APPOINTMENTS

Please understand that appointment time in any dental office is limited and valuable. Therefore, we request kindly that all patients honor their reserved appointment time. Failure to do so deprives other patients from receiving needed dental care in a timely fashion.

So that I the dentist and my staff will not be penalized by those who fail to keep their appointments, $50.00 per hour broken fee Monday- Thursday and a $75.00 charge per hour broken fee Friday/Saturday. This fee will not be charged if we receive 24 hour notice for Monday-Thursday and a 48 hour notice Friday/Saturday prior to your scheduled appointment time. The patient is responsible for the charge and it is to be paid prior to the scheduling of any new appointment.

FEES AND FINANCIAL ARRANGEMENTS

Any patient with insurance must bring in an insurance card. It is the patient's responsibility to advise the staff of any insurance changes along with address and phone numbers of the insurance company.

TREATMENT RECOMMENDATIONS

Dr. Lee and her staff strive to provide the most accurate and most complete treatment plan possible. In the event there is a discrepancy between the fees presented in the treatment plan and the final amount, keep in mind we estimate the insurance coverage and the insurance company may pay less or more than was estimated. Also, Dr. Lee may have to alter her original treatment in order to provide the best dental care for you.

ACCOUNTS WITH DENTAL INSURANCE

Please remember that if we accept and file your insurance, it is a courtesy to you. However the relationship is between you and your insurance company. The patient is always responsible for his or her portion at the time service is performed. After 30 days the total amount becomes the responsibility of the patient or the guarantor. (parent or guardian) Unless arrangements are made with the office, the account will then be susceptible for collections. Please note that our office will not be responsible for filing secondary claims; this is the responsibility of the patient.

WE ACCEPT CASH, CHECK, DEBIT, VISA, MASTERCARD, AND DISCOVER

Signature_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

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 Feb. 27, 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.

Health Care Operations: We may use and disclose 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, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide with an opportunity to object to such uses or disclosure 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, postcard, or letters).

PATIENTS 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 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 $0 for each page, $0 per hour for staff to locate and copy your health information, and postage if you want 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 ends of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have a 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 request.

Restrict: 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 Communications: 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure if your health information or to have is communicate with you by alternative means or at alternative location, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Rana Lee, D.D.S.,**

Telephone: **972-790-5055** Fax: **972-986-7760**

E-mail: **ranaleedds@verizon.net**

Address: **2204 W. Shady Grove Rd. Irving TX 75060**

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ViziLitePRO

Oral Lesion Screening System

Adjunctive Oral Abnormalities Screening Form

Complete each time the exam is offered and place in the patient's file

Our practice continually strives to provide important enhancements in oral healthcare for our patients. We are concerned about your oral abnormalities and their relationship with serious diseases such as oral cancer. For this reason, we offer screenings to every patient for early detection.

Oral cancer is one of the deadliest diseases we encounter and research shows that the late detection of oral cancer is the primary reason that mortality rates are high. As is the case with most other cancers, age is a primary risk factor for oral cancer. Tobacco use and chronic alcohol consumption are also major risk factors.

We find that using ViziLite PRO- along with a visual examination- improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of abnormalities can minimize or eliminate the harmful and potentially disfiguring effects of serious oral diseases such as cancer, and possibly save your life. A painless exam gives us a better chance of finding any oral abnormalities you may have at an early stage. In our practice, the exam will be offered to you annually.

Dental insurance may or may not cover the exam. However, our office us happy to verify your coverage for you. We are asking patients pay the fee upfront, and we will file it to your insurance. The fee for this exam is **$15.00 .**

☐ Yes. I authorize my dental professional to perform the ViziLite PRO screening along with the standard oral examination. I accept financial responsibility for this exam.

☐ No. I would prefer not to have abnormality screening at this time.

Print name:_____

Signature_____ Date:_____

Oral cancer risks include:

- Tobacco use
- Chronic alcohol consumption
- Oral HPV 16/18 infection

1-800-4DENMAT
(1-800-433-6628)
www.denmat.com

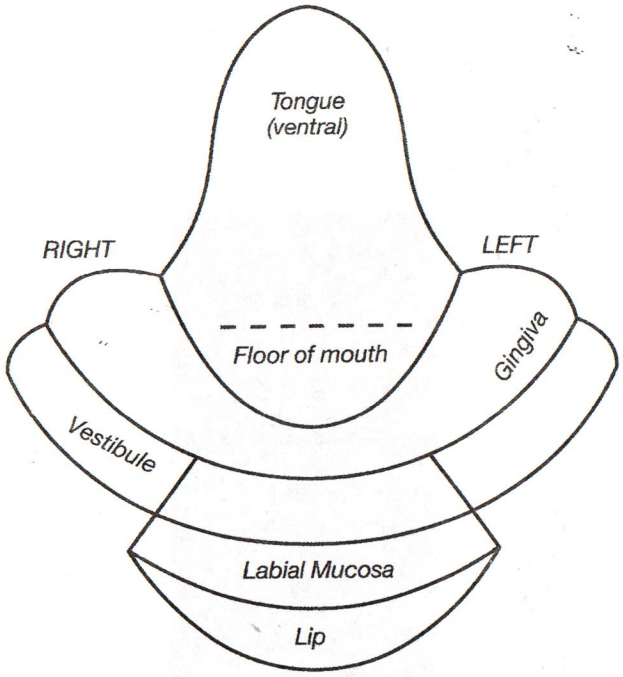
DenMat

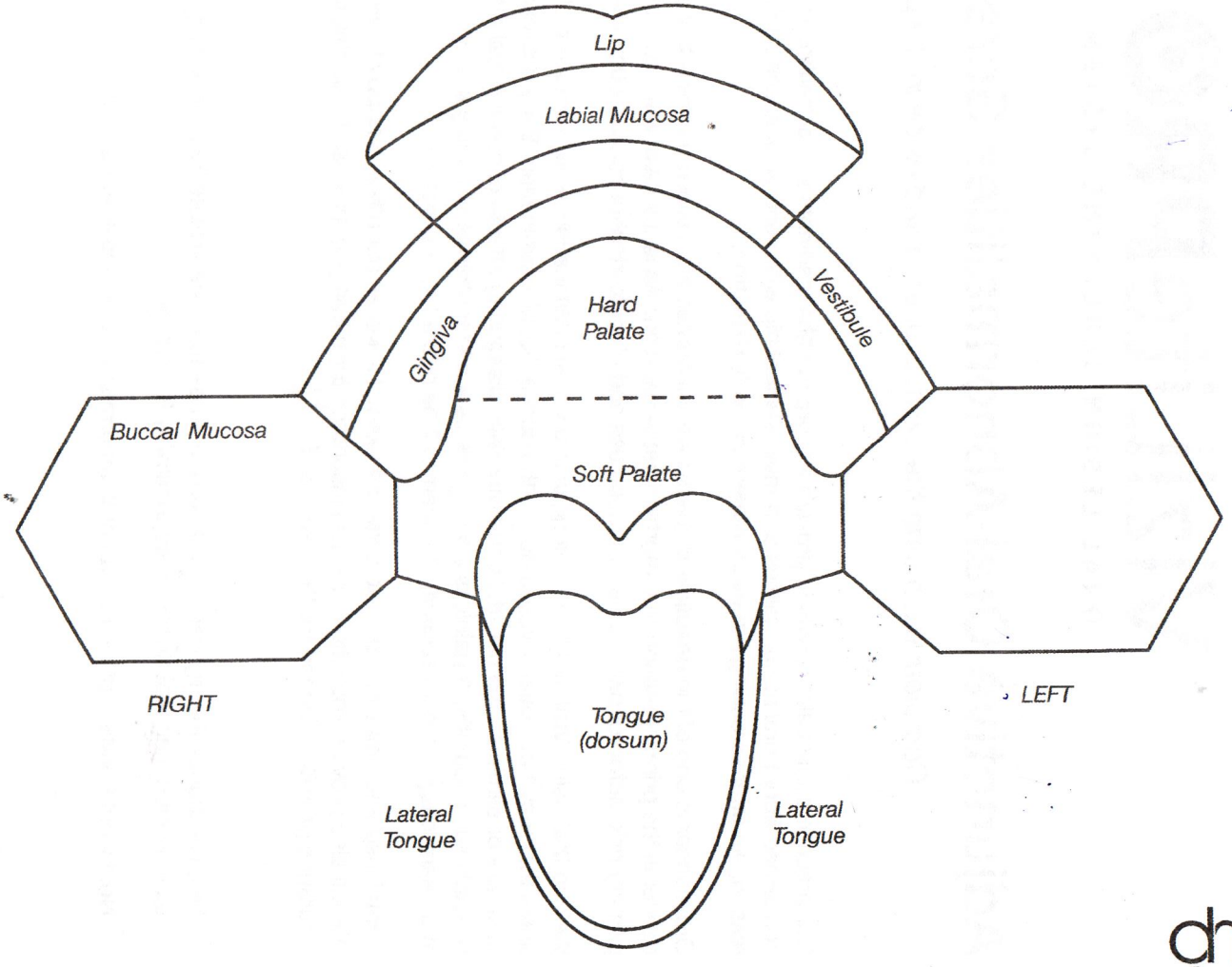
Patient Name: _____ ID: _____

Signature: _____ Date: _____

ViziLitePRO
ORAL LESION SCREENING SYSTEM

Highest Risk Sites:
- Lateral border of tongue
- Lip
- Anterior floor of mouth
- Soft Palate





DenMat

Rana Lee D.D.S
2204 West Shady Grove Rd.
Irving , Tx 75060
972-790-5055

Name _____

Date _____

COVID-19 Pandemic- Patient Disclosures

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

Witness **Date**

COVID-19 PANDEMIC DENTAL TREATMENT
NOTICE AND ACKNOWLEDGMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease and has been classified a pandemic by the World Health Organization. Contracting the virus can be from a variety of sources. Our practice wants to ensure that you are aware of the additional risks that can be associated with receiving dental care.

The COVID-19 virus has a long incubation period (about 14 days). You or your healthcare providers may have the virus and not show any symptoms yet, and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to availability of testing and length of time for results to be received.

Due to the frequency and timing of visits by multiple patients within this office at the same time, the characteristics of the virus, and the characteristics of dental procedures in general, there is an elevated possible risk for contracting the virus simply by being in the dental office.

Some dental procedures create water spray which is one way the disease can be spread. The ultra –fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask or covering over your mouth during any dental procedure, as your healthcare provider will need access to your mouth to render care. This leaves you more vulnerable to COVID-19 transmission while receiving your dental care.

This office performs all recommended CDC and ADA sterilization and disinfection protocols, and we have added extra, additional safety measures to ensure that all patients and staff are protected as much as can be reasonably expected in the environment that is a dental office. Any patient that presents with any questionable symptoms or possible exposure evidence will be rescheduled to a later date, when that said patient will no longer be a danger to this office or others.

Patients are asked to notify our office within 24-48 hours of any symptoms arising from possible COVID-19 after any dental visit, so that other patients seen on the same date can be notified to be checked by their physician for possible infection. We also ask patients to call our office after 14 days from their appointment date to notify us of any changes to their health status, if it has changed since they were seen.

Every attempt has been made to make your visit in this office as safe as possible; the health and safety of our patients and staff is our top priority, and we take every precaution necessary to ensure it.

I confirm that I have read the Notice above and understand and accept that there is a risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment in the office today, and understand and accept the possible risks of contracting the virus from contact at this office. I acknowledge that I could also contract the COVID-19 virus from outside this office and be unrelated to my visit here today.

I have read and understand the information stated above:

_____ _____

Signature Date

_____

Witness