TIME 10:10 AM LEE TREVINO DENTAL DATE 7/1/2014

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 _____

REGISTRATION HISTORY

Please complete the following confidential information

Date _____

Name _____
Last First Middle

Address _____ Apt. _____

_____
City State Zip

Home Phone (____) _____

Cellular Phone (____) _____

Birthdate _____ Age _____

Social Security # _____

Married _____ Single _____ Divorced _____ Widowed _____

DENTAL INSURANCE INFORMATION

Insured's Name _____
Last First Middle

Insurance Company _____

Address _____

Insured's Employer _____

Insurance Phone # _____

Group or I.D. # _____

Insured's Social Security # _____

IF SECONDARY COVERAGE

Insured's Name _____
Last First Middle

Insurance Company _____

Address _____

Insured's Employer _____

Insurance Phone # _____

Group or I.D. # _____

Insured's Social Security # _____

NOTE: If our office accepts benefit assignment on your insurance we can only ESTIMATE your benefits. The responsible party is responsible for the TOTAL COST.

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

Is another member of your family, or relative a patient at our office? _____ If so, relationship _____

ACCOUNT INFORMATION

Are you: Married_____ Divorced_____ Separated_____ Single_____ Widowed_____

Occupation _____ Work Phone # ( ) _____ Ext. # _____

Employer _____ Employer's Address _____

Spouses Name _____ Occupation _____ Work Phone # _____ Ext. # _____

Employer _____ Employer's Address _____

Nearest Relative not living with you _____ Relationship _____ Phone # ( ) _____

Address _____ City _____ State _____ Zip _____

Lee Trevino Dental

Acknowledgement of Receipt of NOTICE OF PRIVACY PRACTICES

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

_____

Print name

_____

Signature

For office use only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_____Patient refused to sign

_____Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (describe below)

_____

_____

_____

APPOINTMENT POLICY

Dr. Bransford and his staff strive to deliver the highest quality service, knowing that is what you deserve. To accomplish this, it will be necessary to ask our patients to make the following agreements:

_____ Help us keep our **"no patient waiting"** policy. We are making every effort to stay on schedule for your appointments. We reserve the right to reschedule anyone arriving more than 10 minutes late.

_____ We will be contacting you via phone call prior to your appointment. We ask you to call to acknowledge you have received the message.

_____ Your appointment time to is reserved just for you, because you are important to us. Please give our office 24 hours notice of any cancellations, so that we may re schedule you, as well as give someone else the opportunity of filling your appointment.

_____ Parents of minors (or responsible party of minors) MUST BE PRESENT to make financial and treatment decisions, and give consent for those treatments. If you are only to drop the minor off, or if the minors are driving themselves, prior written consent and payment arrangements must be made in advance. This applies to **EVERY** appointment.

_____

PRINTED NAME

_____ _____

SIGNATURE **DATE**

LEE TREVINO DENTAL CARE, PLLC

RICHARD W. BRANSFORD, D.D.S.

1624 LEE TREVINO, STE. A

EL PASO, TX 79936

CLIENT ACKNOWLEDGMENT STATEMENT

"I understand that, the services provided to me by Lee Trevino Dental Care PLLC, may not be covered 100% by my dental insurance. Therefore, I agree to pay in full any remaining balance."

_____ _____

Patient's Signature Date

DECLARACION DEL RECONOCIMIENTO DEL CLIENTE

"Comprendo que si el tratamiento dental que solicite de Lee Trevino Dental Care PPLC, no es cubierto al 100% por mi aseguranza dental, yo me ago responsable por el balance pendiente."

_____ _____

Firma del Paciente Fecha

I understand that the services provided to me by Lee Trevino Dental Care PLLC are to be paid in full as services are rendered. Therefore, I agree to pay any balance on the day of appointment.

Responsible Party:

Name:_____ **DOB:**_____

Address:_____

Telephone No.: (H)_____ **(W)**_____
(C)_____

Social Security:_____

Notice of Privacy Practice
Lee Trevino Dental

This notice describes how health information may be used and disclosed and how you can access this information. Please read it carefully. If you have any questions about this notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal Law to give you this notice and to maintain the privacy of your health information. We must also abide by the terms of this notice while it is in effect. We reserve the right to change our privacy practices and the terms of this notice at any time. Before we make significant changes in our privacy practices, we will change this notice and make the new notice available upon request.

Uses and Disclosures of Protected Health Information

You will be asked to sign an **Acknowledgement of Notice of privacy Practices.** Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and healthcare operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you.

Treatment; we will use and disclose to other dentists and physicians your protected health information to provide, coordinate or manage your healthcare. For example, your protected health information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at any time to a dental laboratory or specialist.

Payment; Your protected health information will be used to obtain payment for services we provide you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations; We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee reviews, licensing, credentialing, and conducting other business activities. For example, we may use a sign-in sheet at the registration desk where you will asked to sign your name and indicate your doctor. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Business Associates; We will share your protected health information with third party Business Associates that perform various activities (billing or laboratories) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as appropriate, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and services we offer. We may also send you information about products that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time in writing, except to the extent that our practice has already taken an action as provided in the authorization which was then in affect.

Other Permitted and Required Uses and Disclosure That May be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected information. If you are not present or able to agree or object to the use or disclosure of the projected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.

Family and Friends; Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person whom you identify your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment to make reasonable decisions in your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays, or other similar forms of health information.

Other Permitted and Required Uses and Disclosures That May be Made Without Your consent

Required by Law; We may use or disclose your protected health information when required to do so by law.

Emergencies; We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your acknowledgment of receipt of Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, 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.

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 and safety to others.

Military Activity and 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 institutions or law enforcement officials having lawful custody, the protected health information of inmates or patients under certain circumstances.

Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance.

Your Rights

You have the right to inspect and copy your protected health information. You have the right to look at or get copies or 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 practically do so. You must make the 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 prefer, we will prepare a summery or an explanation of your health information for a fee.

You have the right to inspect and copy your protected health information. 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 abide by our agreement, except in an emergency.

You have the right to request alternative communications from us, You have the right to request that we communicate with you about your health information by 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.

You have the right to request an amendment to your health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information. This right applies to disclosures for purposes other than treatment or payment of healthcare operations as described in the notice. It excludes disclosures we may have made to your family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request paperwork from the same account more than once in a 12 month period, we may charge you a reasonable cost based fee for responding to these additional requests.

You have the right to make complaints about our Privacy Policies. If you are concerned that we have violated you privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the bottom of this page. You may also file a complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department of Health and Human Services.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date: May 1, 2012
Privacy Officer: Dr. R. Wes Bransford
Address: 1624 N. Lee Trevino Ste. A
El Paso, TX 79936

Phone: (915)593-8815
Fax: (915)593-8857
Email: leetrevinodental@yahoo.com