Welcome

ABOUT YOU

Today's Date: ____________________ E-mail Address: ________________________________

Name: ____ I prefer to be called: ____________________ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _______ Social Security #: ____________________ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: ____
Street City State Zip

Home Phone #: (_____)__________ Cell #: (_____)__________ Work Phone #: (_____)__________ Ext: ____ Driver License #: ____________

Where & when are best times to reach you? ____________________ Whom may we Thank for referring you? ____________________

Other family members seen by us: ____

Employer: ____________________ How long there? __________ Occupation: ____________________

Employer's Address: ____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: ____________________ Relation: __________ Work Phone #: (_____)__________ Home Phone #: (_____)__________

Address: ____
Street City State Zip

Person Responsible for Account if other than yourself

Name: ____________________ Relation: __________ Home Phone #: (_____)__________ Social Security #: ____________________

Employer: ____________________ Work Phone #: (_____)__________ Ext: ____ Drivers License #: ____________________

Billing Address: ____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: ________________________________ Birthdate: ___/___/___ Social Security #: ____________________

Employer: ____________________ Work Phone #: (_____)__________ Ext: _____ Drivers License #: ____________

INSURANCE INFORMATION

Primary Insurance Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ____________________ Phone #: (_____)__________ Group # (Plan, Local or Policy #): ____________

Insurance Co. Address: ____
Street/PO Box City State Zip

Insured's Name: ____________________ Insured's Social Security #: ____________ Insured's Birthdate: ___/___/___ Relation: ________

Insured's Employer: ____________________ Employer's Address: ____________________
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ____________________ Phone #: (_____)__________ Group # (Plan, Local or Policy #): ____________

Insurance Co. Address: ____
Street/PO Box City State Zip

Insured's Name: ____________________ Insured's Social Security #: ____________ Insured's Birthdate: ___/___/___ Relation: ________

Insured's Employer: ____________________ Employer's Address: ____________________
Street/PO Box City State Zip

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today? ______________________

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long do you use a toothbrush before replacing it? ______________

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? ______________________

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ______________

Do you still have wisdom teeth? ❑ Yes ❑ No

If yes, why? ______________________

Previous / Present Dentist: ______________ Last Visit Date: ________
(Please Circle)

Why did you leave your previous dentist? ______________

What did you like most & least about any dentist you have seen? ______________

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? ______________________

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No Date of last visit: __________

Physician's Name: ______________________

Address: ______________________ Phone #: (___) ______________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ______________________

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❑ Yes ❑ No

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions: ______________

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: ________ Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid Medicine
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	
Y N Aspirin	Y N Digitalis/Heart Medication	Y N Steroids/Cortisone	

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ❑ Yes ❑ No If yes, please list each one: ______________

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Osteoporosis/Paget's Disease	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Psychiatric Treatment	Y N Tonsillitis
Y N Cancer	Y N Fever Blisters	Y N HIV+/AIDS	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for Any Reason	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: ______________

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be ______________.

____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by ______________ Insurance Co. and I assign directly to Dr. ______________ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____
Signature Date

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HIPAA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Treva Lee, D.D.S.

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (S 164.508(a))

I, ___________________________ (Patent's name) understand that as part of my health care, Treva Lee, D.D.S, originates and maintains health records describing, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Treva Lee, D.D.S notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of Protected Health Information for treatment, Payment, or Healthcare Operations (S 164.506 (a))

I understand that:

- I have the right to review Treva Lee, D.D.S Notice of Information practices prior to signing this consent;
- That Treva Lee, D.D.S, reserves the right to change the notice and practices and that prior to implementation we will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations that Treva Lee, D.D.S, is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Treva Lee, D.D.S, has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: ________________________________

Printed Name of Patient or Legal Representative Witness: ________________________________

Date: ________________________________

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HIPAA PRIVACY RULE RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

TREVA LEE, D.D.S

Acknowledgement of receipt of Information Practices Notice (S 164.520(a))

I, ________________________ (Patient's Name), understand that as part of my health care, Treva Lee, D.D.S originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care of treatment. I acknowledge that I have been provided with and understand that Treva Lee, D.D.S. *Notice of Privacy Practices* provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Treva Lee, D.D.S. Notice of Privacy Practices prior to signing this acknowledgement;
- That Treva Lee, D.D.S. reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I have provided if requested.

Signature of Patient or Legal Representative Witness: ________________________________

Printed Name of Patient or Legal Representative Witness: ________________________________

Date: ________________________________

FOR OFFICE USE ONLY

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

____

____

________________________________ ________________________________

Treva D. Lee, D.D.S. Date

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OFFICE PROCEDURES REGARDING HIPAA

Treva Lee, D.D.S.

1. It is our practice that we will address your by your first and/or last name.

2. Phone Confirmations: It is our office procedure that we may call you to confirm your appointment. We my also call you regarding medical issues. Which two phone numbers would you like us to call you at?: ________________________ and ________________________.
   If we can not reach you at these two numbers, we may call you at home. If no one is home to take a message, we will leave you a message on your answering machine.

3. TEXT MESSAGING AND EMAIL CONFIRMATIONS: Our office is now using text and email confirmations. Also we will be emailing newsletters and announcements.
   ______ (initial) Yes I would like to have my appointments confirmed by text and email.
   Cell#: ______________________________
   Email: ______________________________
   ______ (initial) No I would not like to be contacted by text or email.

4. Verbal Authorization: It is our office procedure to get verbal authorization from new patients to confirm appointments and leave messages if the patient is not available. It is also our procedure that we get your insurance information so we can confirm the status of your insurance for treatment as needed.

5. Photo and Video Examinations: It is our office procedure that we may take photos or video during your examinations. These images may remain part of your medical record or be used for educational purposes.

6. Written Communication: It is our office procedure to communicate with you by means of letters, postcards, faxes, and e-mail.

7. Referrals: It is our office procedure to communicate with other health professionals, pharmacies, or labs regarding your medical issues by phone, letters, postcards, faxes, and e-mail.

8. Our office is HIPAA compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health Information. However, the HIPAA laws are still being written, so please be respectful of other patient's privacy.

9. I authorize the following person/persons to be my personal representative and authorize treatment, which means the doctor and staff may speak freely regarding all my protected health information, medical and treatment matters and billing. However, I understand that I am still responsible for the billing:

Name	Relationship to Patient
______________________________	______________________________
______________________________	______________________________

I, ____________________________________ agree to all of the above procedures of Treva D. Lee, D.D.S. and give my authorization to all of the above procedures.

Signature of Patient or Legal Representative: ____

Date: ________________________________

Dr. Treva Diane Lee , D.D.S., MAGD

2630 N. Fresno St. #101 | FRESNO CA, 93703 | (559) 226-3010

Written Financial Policy

Thank you for choosing Treva Lee , D.D.S., MAGD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $1000 or more.

- Convenient Monthly Payment Plans[1] from CareCredit or Chase Health Advance
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Dr. Treva Diane Lee , D.D.S., MAGD requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds. For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $1000 or more, a 1/3 deposit may be required to secure your initial treatment appointment.

Ask us about our in-house financing.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Dr. Treva Diane Lee, D.D.S., MAGD charges a NSF Fee for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from you or your insurance carrier within 60 days, you will be responsible for payment of your treatment and collection fees that may be applied to your account.

Dr. Treva Diane Lee, DDS
Master of Academy of General Dentistry

FINANCIAL AGREEMENT

Our mission is to deliver the finest, most cost effective health care treatment available today. Following diagnosis, the doctor will advise you on your plan for treatment. Additionally, we will discuss with you the cost of today's and future treatments.

Payment for today's visit and your future visits are due at the time of treatment. We are sensitive to the fact that some people may not be able to pay cash at time of treatment; therefore, we offer an extended monthly payment plan for your convenience.

If you have dental insurance, please remember that your dental insurance is your responsibility… but we can help. Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you, the patient, are responsible for the total fee of treatment performed. As a courtesy to you, we can accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. The outlined estimate is based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make a payment. After this time all inquiries (follow-up) on payments due become your responsibility.

Please indicate below the form of payment that you wish to choose to settle your account:

___ Cash or Check (5% courtesy discount will be given if payment for treatment over $1,000 is made in full prior to treatment)

___ Visa/ MasterCard/American Express/ Novus Discover

___ Financing Option – If you choose this option, please let us know so we can provide you with an application. (Offers no interest payments plans and extended payment plans)

I agree to the FINANCIAL RESPONSIBILITY for the total fee. The fees listed on the treatment outline will be honored for 90 days from the date below. After that time, the fees are subject to adjustments. If this account is turned over to collections I understand that I am responsible for any collections fees.

Signature____ Date_____________
(Patient/Parent/Guardian)

Dr. Treva Diane Lee, DDS
Master of Academy of General Dentistry

PROCEDURAL CONSENT

Patients Name:____

Removal of Teeth: Initials:_______

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment, I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissues that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Crowns, Bridges, Veneers, Inlays/Onlays: Initials:________

I understand that sometimes it is not possible to match the color or natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary, provisional crowns/restorations, which may come off easily and that I must be careful to ensure that they are kept on until the permanent restorations are placed. I realize the final opportunity to make changes in my new restoration (including shape, fit, size, and color) will be before cementation.

Dentures: Complete or Partial Initials:________

I realize that full or partial dentures are artificial , constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new prostheses (shape, fit, size, position, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately 3 to 12 months after initial placement. The cost for this procedure is not included in the initial denture fee.

Endodontic Treatment (Root Canal): Initials:________

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root which does not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures (apicoectomy) may be necessary following root canal treatment and that additional procedure may be necessary to complete restore the tooth. The cost for these procedures is not included in the root canal therapy fee.

Periodontal Loss (Tissue and Bone): Initials:________

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and or extractions. I understand that undertaking any dental procedures may have a future-adverse effect on my periodontal condition.

Dr. Treva Diane Lee, DDS
Master of Academy of General Dentistry

INFORMED CONSENT

Patient's Name: ____

I hereby grant authority to Dr. Treva D. Lee to administer such anesthetics, analgesics, sedatives, medications, or sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of the above-named patient.

I understand that dentistry is not an exact science and that reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized.

Drugs and Medication:
I understand that antibiotics and analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, nausea, and/or anaphylactic shock (severe allergic reaction).

Treatment Plan Changes:
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination… the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Photography Release:
I understand that I may have photographs taken and they may be used for illustration and for documentation of my treatment. Other professionals and the public for teaching purposes may also view them.

Signature: ________________________________ Date: ________________
(Patient/Parent/Guardian)

Doctor: ________________________ Witness: ________________________

Photo Release Form

I grant permission to Dr. Treva Lee D.D.S. to use photographs/videos taken by our photographers/videographers for use on our web sites or other electronic form or media without notifying me.

I hereby waive any right to inspect or approve the photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the photographs.

I hereby agree to release and hold harmless Dr. Treva Lee D.D.S., via electronic or media, from and against any claims, damages or liability arising from or related to the use of the photographs, including but not limited to any re-use, distortion, blurring, alteration, optical illusion or use in composite form, either intentionally or otherwise, that may occur or be produced in production of the finished product.

I am 18 years of age and I am competent to contact in my own name. If I am not 18 years of age or older, a legal parent or guardian has signed this waiver on my behalf. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Photo Subject Name: ____

Parent or Legal Guardian: ____

Address: ____

E-Mail: ____

Signature: ______________________________________

Date: ______________________________

☐ I do not wish to release photos/videos

Smile Evaluation

Are you happy with your smile?____

____

Would you like your teeth to be whiter?____

____

Would you like your teeth to be straighter?______________________________________

____

Do you have spaces between your teeth that you would like closed?______________________

____

Do you like the shape of your teeth?____

____

Do you like the length of your teeth?____

____

Do you have missing teeth you would like to replace?_______________________________

____

Do you have old silver fillings that you would like to replace with tooth colored fillings?__________

____

If you could change anything about your smile what would you change?____________________

____