Ayas Family Dentistry, P.C.
Family Dental Practice

GENERAL INFORMATION

Date: _____ Who refered you to our office?_____

Patient: _____ Nickname:_____

Address: _____

(City,State,Zip) _____

Date of Birth: _____ Social Security: _____ Email: _____

Sex: _____Male ____ Female Status: __Single __ Married __ Widowed __Separated __ Divorced

*******Please complete if patient is_ 18 or over.***

Employer: _____ Occupation: _____

Spouse Name: _____ Spouse Occupation: _____

Spouse Employer: _____ Spouse Work Phone:_____

*******Please complete if patient is <u>UNDER</u> 18.***

Mother Name: _____ Date of Birth:_____

Employer: _____ Occupation:_____

Work Phone: _____ Cell Phone:_____

Social Security Number: _____

Father Name: _____ Date of Birth:_____

Employer: _____ Occupation:_____

Work Phone: _____ Cell Phone:_____

Social Security Number: _____

PHONE NUMBERS

Home: _____ Work:_____

Cell:_____ Other Number:_____

In case of emergency contact (please list someone who does <u>not</u> live in your household)

Name: _____ Relationship: _____

Home Phone: _____Work: _____ Cell: _____

DENTAL INSURANCE

Subscriber's Name: _____ Subscriber's Date of Birth:_____

Subscriber's Social or ID #:_____ Relationship to Patient:_____

Employer:_____ Group #:_____

Insurance Name:_____ Insurance Phone :_____

I, the undersigned certify that I (or my dependent) have insurance coverage. And assign directly to Dr Ayas, DDS, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____ _____

Responsible Party Signature Date

MEDICAL HISTORY/INFORMATION

Please mark yes or no to the following:

yes no AIDS/HIV	yes no Cortisone Treatments	yes no Jaw Pain	yes no Shortness of Breath
yes no Anemia	yes no Cough, persistent	yes no Joint Replacement	yes no Sinus Trouble
yes no Arthritis, Rheumatism	or bloody	yes no Kidney Disease	yes no Skin Rash
yes no Artificial Heart Valves	yes no Diabetes	yes no Liver Disease	yes no Stroke
yes no Artificial Joints	yes no Emphysema	yes no Low Blood Pressure	yes no Swelling of Feet or Ankles
yes no Asthma	yes no Epilepsy	yes no Mitral Valve Prolapsed	yes no Swollen Neck Glands
yes no Back Problems	yes no Fainting or dizziness	yes no Nervous Problems	yes no Thyroid Problems
yes no Bleeding Abnormally,	yes no Glaucoma	yes no Nursing	yes no Tonsillitis
with extraction or surgery	yes no Headaches	yes no Pacemaker	yes no Tuberculosis
yes no Blood Disease	yes no Heart Murmur	yes no Pregnant	yes no Tumor or growth on head and neck
yes no Cancer	yes no Heart Problems	*Due Date*_____	yes no Ulcer
yes no Chemical Dependency	yes no Hepatitis Type _____	yes no Psychiatric Care	yes no Venereal Disease
yes no Chemotherapy	yes no Herpes	yes no Radiation Treatment	yes no Weight Loss, unexplained
yes no Circulatory Problems	yes no High Blood Pressure	yes no Respiratory Disease	yes no Others _____
yes no Congenital Heart Lesions	yes no Jaundice	yes no Rheumatic Fever	

Attending Medical Doctor: _____ Dr's phone _____ City, State_____

Have you had any recent Surgery? ___yes ___no if yes please explain:_____

Have you ever taken the group of drugs collectively referred to as "fen-phen". These includes combinations of Longman, Adipex, Fastin (Phentermine), Pondimin (fenfluramine)) &/or Redux/(Dexfenfluramine) ____ yes ____ no

Are you taking or have taken Foxamax? ____yes ____ no

Do you wear contact lenses: ___yes ___no

Are you taking birth control pills? (women only) ___yes ___no

MEDICATIONS

Pharmacy Name: _____ Phone: _____

Are you currently taking any medications (either prescription &/or over the counter ? ____yes ____no

If yes, please list any medications you are currently taking and the correlating diagnosis:

_____

_____

ALLERGIES

Are you allergic to anything we need to be aware of? _____yes _____no

If yes, please note:

____ Aspirin	____ Codeine	_____ Latex	____ Penicillin
____ Barbiturates	____ Iodine	____ Local Anesthetic	____ Sulfa

_____ Others: please list:_____

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist:_____ City/State: _____

Date of last dental visit: _____ Date of last dental X-rays:_____

SIGNATURE

The information that I have given is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes. I authorize the dental staff to perform the necessary dental services on me &/or my dependent.

X _____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I also give permission to Art of Dentistry the authorization to use and or disclose my protected health information to:

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

Employee signature *Date*

E-MAIL/FAX/TEXTING RELEASE FORM

Date: _____

I, _____ (Patient/Guardian's Name) want to communicate via e-mail, fax or texting with Art of Dentistry on matters related to my health and /or my medical treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. And that any information Art of Dentistry sends is also unsecure. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail, fax or texting.

I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail, fax or texting. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

Name: _____

(Print Patient's Name or Name of Patient's Representative)

Signature: _____

(Signature of Patient or Patient's Representative)

Witnessed by: _____

(Print Name)

Signature: _____

(Signature of Witness)

Art of Dentistry
3620 S. Cooper St, Suite 140
Arlington, TX 76015
(817) 468-8839

Welcome to our practice:

Thank you for choosing our office as your dental care provider. As always, our primary goal is to provide the finest dental care available to all our patients. In order for our relationship to be cordial and satisfactory, we would like to inform you of our office policies.

FINANCIAL POLICIES:

Payment: Payment is due in full at the time of service unless prior arrangement as been made and approved in advance by our staff. We accept cash, bank card, Visa/MC, Discover, Care Credit and personal checks with valid I.D or Driver's License.

Missed and/or Late Cancelled Appointments: To better control the cost of dental care, guidelines have been established regarding missed and late cancelled appointments. Failure to give sufficient notice of at least 24 hours prior (must be cancelled during working hours) will result in a missed or late cancellation charge of at least $45.00.

Minors: A parent or guardian must be present at the time of appointment, unless prior notice, consents and financials have been taken care of prior to the appointment. We request that parents/guardian to stay in the waiting room unless requested by the Dentist and or staff.

Insurance Assignment: While the patient is responsible for the total cost of treatment, as a courtesy we will file insurance on the patient's behalf (in most cases.) At the time of service, we estimate the insurance payment and collect the patient portion not expected to cover by insurance. Because we are a third party to your insurance company we can not guarantee what your insurance will or will not pay regardless of any quotes and/or pre estimations. Payments from dental insurance companies are accepted; however, the patient is responsible for any remaining balance after 45 days, regardless of the status of insurance claims.

RESPONSIBILITY AND CONSENT STATEMENTS:

I understand and acknowledge that I am financially responsible for the services provided for myself or a minor regardless of insurance coverage or payment.

In the event that my account becomes delinquent, I agree to pay all cost of collections, if necessary, including, but is not limited to: reasonable attorney's fees, inquired to satisfy my financial obligations.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working that were not discovered during examination. For example, a root canal followed by restorative procedures.

For diagnostic purposes or dental treatment, I give my consent to any advisable and necessary dental procedures, medication or anesthetics to be administered by the attending dentist or by the supervised staff.

_____
Patient Signature (guardian if minor)

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 8/21/2012 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Tarek Ayas DDS/ Rachel Nguyen. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your protected health information (PHI) including electronic protected health information (ePHI) to provide you with our professional services which may include electronic disclosure. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

(a) Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your health information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $ 25 for each page and the staff time charged will be $ 10 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

(b) Right to Request Restriction of PHI: You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

Payment: We may use and disclose your PHI and ePHI to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get electronic copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ 25 for each page and the staff time charged will be $10 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to request and receive an accounting of certain non-routine disclosures of your identifiable health information. We are required to maintain a log of these non-routine disclosures for a period of no less than six years beginning April 14, 2003. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is 'breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

Practice Name: Ayas Family Dentistry P.C/ DBA Art of Dentistry Privacy Officer: Tarek Ayas DDS/Rachel Nguyen

Telephone: 817-468-8839

Address: 3620 S. Cooper St., Suite 140, Arlington, TX 76015

Email: AyasDentalOfffice@yahoo.com