JULIE D. TRAN, D.D.S.
DEL RAY SMILES
PATIENT INFORMATION

Date _____
Name (first, middle initial, last) _____
Sex: Male ____ Female ____
Please check one: Single _____ Married _____ Child _____ Other _____
Date of Birth _____ Soc. Sec. # _____
Address: _____
City _____ State _____ Zip Code _____
Home Phone: (_____) _____
Work Phone: (_____) _____
Optional: Fax _____ Cell Phone: (_____) _____
Email _____

Employer: _____ Occupation: _____
Address: _____
Referred by: Friend/Coworker_____Sign _____
Insurance _____ Other_____

Name of Dental Insurance: _____
Name of Policy Holder: _____
Soc. Sec # of Employee _____ Date of Birth _____
Relationship to Policy Holder: Self _____ Spouse _____ Parent _____
Policy Holder's Employer _____
Address of Ins. Co. _____
_____
Phone Number of Ins. Co. _____
Individual ID# if different from SSN _____
Group # _____ Policy Holder's Work Phone _____
Policy Holder's Address if different from above _____
_____

In case of emergency please list two contacts:
Name _____ Relationship _____Phone _____
Name _____ Relationship _____Phone _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Dr. Tran or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.
Date: _____ Signature:_____
(Patient or Guardian)

Over please ∧

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____, and assign
Name of insurance company(ies)
directly to Dr. Tran all 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 my insurance submissions whether manual or electronic.

Date: _____ Signature: _____
Signature of Patient/Guardian

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Dr. Tran and/or the dental team for myself or my dependant(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, maximums and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 24 hours prior to my scheduled appointment time. **For any missed appointment a fee of thirty-five ($35) dollars will be assessed to my account for every fifteen minutes scheduled.** This fee covers the cost of office overhead during time set aside specifically for me or for my dependent(s).

We make every effort to schedule appointments that are the most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than five hundred ($500) dollars payment in full is due at the time of service. Any payment plans* I agree to with this office must be completed. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney I agree to pay all collection and attorney fees.

*An 18% (eighteen percent) per annum finance charge is assessed to any account that is more than thirty days old.

Date: _____ Signature: _____
Signature of Patient/Guardian

MINOR/CHILD CONSENT

I, being the parent or guardian of _____, do hereby request and
Name of minor/child
authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: _____ Signature: _____
Signature of Patient/Guardian

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DEL RAY SMILES

Notice of Patient Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED. IT ALSO DESCRIBES HOW YOU CAN ACCESS THIS INFORMATION.

Who Does this Notice Apply To?

Our practice applies this notice to all employees and business contractors of Dr. Tran. Simply put, this means anyone who can come into contact with your health information through our office.

Why Do We Publish This Notice?

As dental professionals, we understand that your health information is personal and private. We are required by law to maintain the privacy of information we gather and use about our patients. We are also required to notify you of our legal obligation to maintain your records with the utmost security.

In the course of providing dental treatment, it is sometimes necessary to share information with other parties. These parties may include dental laboratories, your insurance company or any company that the insurance company utilizes to determine benefits on your behalf.

When Is This Notice Effective?

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 April 11, 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

We use and disclose health information about you and your family for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your family's health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your family's health information to obtain payment for services we provide to your family.

Healthcare Operations: We may use and disclose your family's 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.

Uses And Disclosures Of Health (cont'd)

Your Authorization: In addition to our use of your family's health information for treatment, payment or healthcare operations, you may give us written authorization to use your family's 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 family's health information to you. 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, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event 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, radiographs (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 Procedures: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters). Our office utilizes a sign-in sheet that we ask you to fill in upon your arrival. If you do not wish your name to appear on the sign-in sheet please let our receptionist know.

Patient Rights

Access: You have the right to review and to obtain copies of your family's 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 make 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 a base fee of $10 and $0.50 for each page, for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your 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 end of this Notice for a full explanation of our fee structure.

Patient Rights (cont'd)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your family's 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 requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your family's 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 Communication: You have the right to request that we communicate with you about your family's 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 family's 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.

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 family's privacy rights, or you disagree with a decision we made about access to this health information or in response to a request you made to amend or restrict the use or disclosure of your family's health information or to have us communicate with you by alternative means or at alternative locations, 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: Front Desk
Telephone: 703-836-2213
Address: 4 Herbert St. Alexandria, VA 22305

Oral Cancer Fact Sheet

Consider the facts:

- Each year approximately 30,000 people are diagnosed with cancer of the oral cavity and pharynx.
- The average years of life lost for oral cancer is 16 years, one year more than for all cancers in general.
- More deaths occur annually from oral cancers than from cervical cancer.
- Only half of those diagnosed with oral cancers are still alive after five years.
- The incidence of oral cancer and the mortality rate due to oral cancers has been almost three times greater in males than in females. African Americans have a slightly higher incidence than Caucasians.
- Between 75-90% of oral cancers are attributed to the use of tobacco of all forms.
- Alcohol use also has been positively correlated with the incidence of oral cancers.
- The relative risk for oral cancer created by combined tobacco and alcohol use is substantially greater than that for either smoking or alcohol use alone.
- More than 75% of all oral cancers can be diagnosed by sight or palpation.
- Tongue lesions account for approximately one-third of all oral cancers.
- Oral cancer is considered among the most preventable of cancers.

Early Warning Signs:

- A sore in the mouth that will not heal
- A lump or thickening in the cheek
- Difficulty chewing or swallowing
- Numbness of the tongue or other areas of the mouth
- A white or red patch on the tongue, gums or other oral tissues
- Soreness of feeling that something is caught in the throat
- Difficulty moving the tongue or jaw
- Jaw swelling that causes dentures to fit poorly

Julie D. Tran, D.D.S.
Del Ray Smiles
4 Herbert St., Alexandria, VA 22305 (703)836-2213

Directions for Alexandria office:

From 395 coming from DC:
Take Glebe Road exit. At the light at the end of the ramp, turn left so that you are going south on Glebe Road. When you see the Exxon station, bear to the right (not really a turn, more of a veering off to right) onto West Glebe Road. Take 3rd right onto Mt. Vernon Avenue (McDonald's and car wash are on the corner). Take the second left onto Herbert Street and pull into the red brick condos on the right. We are the building furthest back.

From 395 coming from south (Duke Street/King Street/Edsall Road/Seminary Rd/ Springfield area):
Take the South Glebe Road exit. Stay in right lane and bear right at the end of the ramp. An Exxon station is immediately on the right. Bear to the right at that light (not really a turn, more of a veering off to right) onto West Glebe Road. Make a right onto Mt. Vernon Avenue (McDonald's and car wash on the corner). Take the second left onto Herbert Street and pull into the red brick condos on the right. We are the building furthest back

From Route 1 South (coming from Old Town):
Come north out of Old Town and make a left onto E. Glebe Road. There is a glass shop on the corner and if you pass Target, you've gone too far. Turn left at the first light, which is Commonwealth Avenue. Take the second right which is Herbert Street. Turn into the red brick condos on the left side. We are the building furthest back

From Route 1 North (Crystal City/DC):
Pass the first Glebe Road and turn on E. Glebe Road which is past Target. Turn left at the first light, which is Commonwealth Avenue. Take the second right which is Herbert Street. Turn into the red brick condos on the left side. We are the building furthest back

From Route 50:
Go south on Glebe Road. Go under the I-395 overpass. An Exxon station is immediately on the right. Bear to the right at that light (not really a turn, more of a veering off to right) onto West Glebe Road. Make a right onto Mt. Vernon Avenue (McDonald's and car wash on corner). Take second left onto Herbert Street and pull into the red brick condos on the right. We are toward the rear of the parking lot.

From Route 66:
Take exit 75 which is Route 110. Continue past Pentagon and bear to the left. The road will split and you should stay to the left and go south on Route 1 into Crystal City. Please follow Crystal City directions from here.