Upper Valley Dental Center

ATTENTION: Important Insurance Information
Please read fully and carefully

This statement is necessarily straightforward to prevent any future misunderstandings, disagreements, or disappointments, since it is vital that our patients understand our relationship with insurance companies. If you believe that your dental needs are covered by insurance, please be aware that the dental insurance contract you have is between you and your company, not us and your company. We do not own, control, or influence insurance companies; thus your company has the final decision as to what your policy will cover. Because of the complexities of dental insurance requirements, we provide assistance for you as a *courtesy*.

However, the **primary** responsibility for dealing with your company is fundamentally yours, not ours. Disagreements and misunderstandings are not between this office and the insurance company, but rather between you and the insurance company. Your personal involvement will help to insure the best possible response and service. Your insurance company is far more likely to respond to requests or complaints directly from you rather than from us, after all, you, not we, pay the premiums.

In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full. A denial from your insurance does not release you from your financial obligations to us. Since we have no association with insurance companies, we cannot guarantee, promise, or certify their actions or decisions. Assuming what government or private insurance companies will cover can de disastrous.

I have read and understand the above.

Signature:_____ Date:_____

PATIENT NUMBER

Dr. Brenda B. Phillips
Upper Valley Dental Center
86 48 Old Troy Pike
Huber Heights, OH 45424

PATIENT'S
NAME_____
Last First Initial
IF CHILD:
PARENT'S NAME_____

HOW DO YOU WISH
TO BE ADDRESSED_____
Single☐Married☐ Separated☐ Divorced☐ Widowed☐ Minor☐
RESIDENCE-STREET_____
CITY_____STATE_____ZIP_____
BUSINESS ADDRESS_____
TELEPHONE: RES._____BUS._____
TELEPHONE :CELL_____BUS_____
EMAIL:_____
PATIENT//PARENT EMPLOYED BY_____
SPOUSE EMPLOYED BY_____
PRESENT POSITION_____HOW LONG HELD_____
WHO IS RESPONSIBLE FOR THIS ACCOUNT_____
METHOD OF PAYMENT: Insurance☐Credit Cards☐ Cash☐
PURPOSE OF CALL_____
OTHER FAMILY MEMBERS IN THIS PRACTICE_____
_____
WHOM MAY WE THANK FOR THIS REFERRAL_____
_____
PATIENT SOCIAL SECURITY NO._____
SPOUSE/PARENT SOCIAL SECURITY NO._____
SOMEONE TO NOTIFY IN CASE OF EMERGENCY
NOT LIVING WITH YOU_____
_____
Please print and sign if there is no 2nd Dental Insurance……→

Sex ☐M ☐F Age_____Date of Birth_____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME_____
EMPLOYEE DATE OF BIRTH_____
EMPLOYER_____# YRS._____
NAME OF INSURANCE CO._____
ADDRESS_____
_____
TELEPHONE:_____
PROGRAM OR POLICY #_____
UNION LOCAL OR GROUP_____
SOCIAL SECURITY NO._____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME_____
EMPLOYEE DATE OF BIRTH_____
EMPLOYER_____# YRS._____
NAME OF INSURANCE CO._____
ADDRESS_____
_____
TELEPHONE:_____
PROGRAM OR POLICY #_____
UNION LOCAL OR GROUP_____
SOCIAL SECURITY NO._____

I,_____ have **NO** 2nd DENTAL
INSURANCE COVERAGE_____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.

I understand that Upper Valley Dental Center only provides composite (white/tooth colored) fillings. These fillings generally cost more than amalgam (silver/mercury) fillings for posterior teeth. I, the undersigned accept the financial responsibility for placement of posterior composite fillings.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of Insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care Insurance carrier or payer of my dental benefits may pay less than actual bill for services. **I understand I am financially responsible for payments in full on all accounts.** By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S
SIGNATURE_____Date_____

Registration

REGISTRATION

Upper Valley Dental Center

PATIENT'S NAME_____
Last First Initial Date of Birth

1. Purpose of initial visit_____
   _____
2. Are you aware of a problem?_____
   _____
3. How long since your last dental visit?_____
4. What was done at that time?_____
   _____
5. Previous Dentist's name_____
   Address:_____ Tel. (_____)_____
6. When was the last time your teeth were cleaned?_____

COMMENTS

CIRCLE THE APPROPRIATE ANSWER

7. Have you made regular visits?.....YES NO
8. Were Dental X-Rays taken?.....YES NO
9. Have you lost any teeth or have any teeth been removed?.....YES NO
   Why?_____
10. Have they been replaced?..... YES NO
11. How have they been replaced?
    a. Fixed bridge_____ Age_____
    b. Removable bridge_____ Age_____
    c. Denture_____ Age_____
12. Are you happy with the replacement?.....YES NO
    If no, explain_____
    _____
13. Would you like to know about permanent replacements?.....YES NO
14. Have you ever had any problems/complications with previous dental treatment?……YES NO
    If yes, explain_____
    _____
15. Do you clench or grind your teeth?.....YES NO
16. Does your jaw click or pop?.....YES NO
17. Have you experienced any pain or soreness in the muscles of your face or around your ear?.....YES NO
18. Do you have frequent headaches, neckaches or shoulder aches?.....YES NO
19. Does food get caught between your teeth?.....YES NO
20. Are any of your teeth sensitive to hot_____cold_____sweets_____pressure_____
21. Do your gums bleed or hurt?.....YES NO
    When?_____
22. How often do you brush your teeth?_____When_____
23. Do you use dental floss?.....YES NO
    How often?_____
24. Are any of your teeth loose, tipped or shifted?.....YES NO
25. Are you happy with the appearance of your teeth; do you have any discolored teeth that bother you?.....YES NO
26. How do you feel about your teeth in general?_____
    _____
27. Do you feel your breath is offensive at times?.....YES NO
28. Have you ever had gum treatment or surgery?.....YES NO
    What_____
    Where_____
    When_____
29. Have you had any orthodontic work?.....YES NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?_____
    _____
31. Do you have any questions or concerns?.....YES NO

I certify that the above information is complete and accurate.

PATIENT'S / GUARDIAN'S SIGNATURE_____ DATE_____
DENTIST'S SIGNATURE_____ DATE_____

Dental History

DENTAL HISTORY

Upper Valley Dental Center

PATIENT'S NAME_____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name_____
   Address_____
   _____
2. Are you under a physician's care?.....YES NO
   Since when_____Why_____
3. When was your last complete physical exam?_____
4. Are you taking any medications or substances?_____
   (If yes, please list medications on the back of this form.)
5. Do you routinely take health related substances?.....YES NO
6. Are you allergic to any medications or substances?.....YES NO
7. Do you have any allergies?.....YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?.....YES NO
9. Are you sensitive to any metals or latex?.....YES NO
10. Are you pregnant or suspect you may be?.....YES NO
11. Do you use any birth control medications?.....YES NO
12. Have you ever been treated for or been told you might have heart disease?.....YES NO
13. Do you have a pacemaker or an artificial heart valve implant?.....YES NO
14. Have you ever had rheumatic fever?.....YES NO
15. Are you aware of any heart murmurs?.....YES NO
16. Do you have high or low blood pressure?.....YES NO
17. Have you ever had a serious illness or major surgery?.....YES NO
    If so, explain_____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?.....YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism?.....YES NO
20. Do you have any artificial joints/prosthesis?.....YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc?.....YES NO
22. Have you ever bled excessively after being cut or injured?.....YES NO
23. Do you have any stomach problems?.....YES NO
24. Do you have any kidney problems?.....YES NO
25. Do you have any liver problems?.....YES NO
26. Are you diabetic?.....YES NO
27. Do you have asthma?.....YES NO
28. Do you have epilepsy or seizure disorders?.....YES NO
29. Do you or have you had venereal disease?.....YES NO
30. Have you tested HIV positive?.....YES NO
31. Do you have AIDS?.....YES NO
32. Have you had or do you test positive for hepatitis?.....YES NO
33. Do you or have you had T.B.?.....YES NO
34. Do you smoke, chew, use snuff or any other forms of tobacco?.....YES NO
35. Do you consume alcoholic beverages?.....YES NO
36. Do you habitually use controlled substances?.....YES NO
37. Have you had psychiatric treatment?.....YES NO
38. Do you have any disease, condition, or problem not listed? If so, explain_____
    _____
39. Is there anything else we should know about your health that we have not covered in this form?.....YES NO
40 Would you like to speak to the Doctor privately about any problem?.....YES NO

COMMENTS

I certify that the above information is complete and accurate.

PATIENT'S / GUARDIAN'S SIGNATURE_____ DATE_____

DENTIST'S SIGNATURE_____ DATE_____

Medical History

MEDICAL HISTORY

Dr. Brenda B. Phillips
Upper Valley Dental Center
8648 Old Troy Pike
Huber Heights, OH 45424

PATIENT'S NAME_____
Last First Initial Date of Birth

I hereby authorize Dr. Brenda B. Phillips and whomever she may designate as her assistants, to perform upon me the following operation and/or procedures:

I understand that Upper Valley Dental Center only provides composite (white/tooth colored) fillings. These fillings generally cost more than amalgam (silver/mercury) fillings for posterior teeth. ***I, the undersigned accept the financial responsibility for placement of posterior composite fillings,_____. Please Sign.***

I request and authorize him/her to do whatever he/she deems advisable if any unforeseen conditions arises in the course of these designated operations and/or procedures calling in their judgment, for procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatments and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, and aspiration, and thrombophlebitis (e.g., irration and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications includes post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness, in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

Patient or Guardian's Signature_____ Date _____

Dentist's Signature_____ Date_____

Witness's Signature_____Date_____

Consent

CONSENT FORM

UPPER VALLEY DENTAL CENTER
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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)

_____

_____

_____

UPPER VALLEY DENTAL CENTER
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 **04/14/2003**, 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.

Healthcare Operations: We may use and disclose your 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, 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, 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, postcards, or letters).

PATIENT 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 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 **$0.15** for each page, **$25.00** to duplicate X-Rays of 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.)

Disclosure Accounting: You have the 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 requests.
Restriction: 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 Communication: 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 of your 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:	Upper Valley Dental
Telephone:	937-236-4360
Fax:	937-236-4365
Address:	Upper Valley Dental Center 8648 Old Troy Pike Huber Heights, Ohio 45424