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’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.______________________________

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….→

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____________________

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

Registration
Upper Valley Dental Center

PATIENT’S NAME

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Initial</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

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?

_________________________________________________________________________

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________

   When?

21. Do your gums bleed or hurt?.................................................................................…YES   NO

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
## Medical History

**Upper Valley Dental Center**

**PATIENT’S NAME**

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Initial</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>PATIENT’S / GUARDIAN’S SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENTIST’S SIGNATURE</td>
<td>DATE</td>
</tr>
</tbody>
</table>

**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., irritation 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)

________________________________________

________________________________________

© 2002 American Dental Association
All Rights Reserved
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