

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 be disastrous.

I have read and understand the above.

Signature: _____ Date: _____

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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

Sex M F Age _____ Date of Birth _____

IF CHILD:
 PARENT'S NAME _____

DENTAL INSURANCE 1ST COVERAGE

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 _____
 PATIENT/PARENT EMPLOYED BY _____
 PRESENT POSITION _____ HOW LONG HELD _____
 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 _____

EMPLOYEE NAME _____
 EMPLOYEE DATE OF BIRTH _____
 EMPLOYER _____ # YRS. _____
 NAME OF INSURANCE CO. _____
 ADDRESS _____
 TELEPHONE: _____
 PROGRAM OR POLICY # _____
 UNION LOCAL OR GROUP _____
 SOCIAL SECURITY NO. _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

DENTAL INSURANCE 2ND COVERAGE

PATIENT SOCIAL SECURITY NO. _____
 SPOUSE/PARENT SOCIAL SECURITY NO. _____
 SOMEONE TO NOTIFY IN CASE OF EMERGENCY
 NOT LIVING WITH YOU _____

EMPLOYEE NAME _____
 EMPLOYEE DATE OF BIRTH _____
 EMPLOYER _____ # YRS. _____
 NAME OF INSURANCE CO. _____
 ADDRESS _____
 TELEPHONE: _____
 PROGRAM OR POLICY # _____
 UNION LOCAL OR GROUP _____
 SOCIAL SECURITY NO. _____

Please print and sign if there is no 2nd Dental Insurance.....→

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

Upper Valley Dental Center

PATIENT'S NAME Last First Initial Date of Birth
PARENT'S NAME Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER.

DENTAL HISTORY

- 1. Is this the child's first visit to a dentist? YES NO
2. If not, how long since the last visit to the dentist?
3. When was the last time the teeth were cleaned?
4. Does the child eat between meals? YES NO
5. Does the child eat sweets, such as candy, soda pop, chewing gum? YES NO
6. Does the child eat well balanced meals? YES NO
7. Does the child brush teeth upon arising? YES NO
When going to bed? YES NO
Right after eating meals? YES NO
After eating any food? YES NO
8. Do you live in an area without fluoridated? YES NO
9. Have teeth been treated with fluorides? YES NO
10. Have any cavities been noted in the past? YES NO
11. Were any teeth (baby or permanent) removed by extraction? YES NO
Was it suggested that the space be maintained? YES NO
Was the appliance placed? YES NO
12. Have there been any injuries to teeth, such as falls, blows, chips, etc? YES NO
If so, describe
13. Has the child had any unfavorable dental experiences? YES NO
14. How many children in your family? []
15. Has anyone in the family, including parents, had orthodontics? YES NO
16. Has the child ever received a local anesthetic or any form of anesthetic? YES NO
17. Has the child ever had occlusal sealants? YES NO

COMMENTS

Large empty rectangular box for writing comments.

MEDICAL HISTORY

- 1. Is the child in good health? YES NO
2. Is the child under care of a physician? YES NO
If yes, since when Why
3. Name of the physician
4. Is the child receiving any medication? YES NO
When Why
5. Has the child had any serious illness? YES NO
When Why
6. Is the child allergic to penicillin, antibiotics or other drugs? YES NO
7. Does the child have any other allergies? YES NO
8. Has the child had any surgery? YES NO
9. Is surgery contemplated? YES NO
10. Is the child subject to profuse bleeding? YES NO
11. Is the child subject to nervous disorders? YES NO
Fainting? YES NO
Dizziness? YES NO
12. Has the child had any history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection.

I certify that the above information is complete and accurate.

PATIENT'S / GUARDIAN'S SIGNATURE DATE
DENTIST'S SIGNATURE DATE

ANEST

Child Dental

CHILD DENTAL MEDICAL HISTORY

MED.ALERT

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)

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