

WELCOME TO



Treatment will not begin unless this form is completed and signed in its entirety. Thank you.

Today's Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY 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 provide this notice to you regarding our privacy practices, legal duty, and your rights concerning your healthcare information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **August 14, 2002**, and will remain 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. Please contact us using the information listed at the end of this Notice for more information about our policy, or for additional copies.

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 or disclose your health information to obtain payment for the services we provide to you.

Healthcare Operations: We may use or 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 healthcare 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 authorization, you may revoke it 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 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

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your care, 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 judgement 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 and 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 healthcare information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional Institution or law enforcement officials 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).

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 predictably 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 upon the 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 fee for each page or set fee complying with the Michigan Medical Records Act from April 1, 2004 (updated yearly) including processing (this is at no profit). 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 disclose your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for up to the last 7 years, but not before 09/01/2019. 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 that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing with date & time). Your

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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.

If you want more information about our privacy practices, or have questions, 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 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 the right to the privacy of your health information. We will not hesitate 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: Anthony Valentine D.D.S.
Telephone: (734) 662-6772
Fax: (734) 662-6778
Address: 1121 E. Stadium Blvd.
Ann Arbor, MI 48104

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Valentine Dental Care Medical and Dental Health History Form

Full Legal Name (First+Last): _____

Preferred Name: _____ Height: _____ Weight: _____

Date of Birth: _____ Blood Pressure: _____

Name of previous dentist/location: _____

Date of last dental examination: _____

Date of last cleaning: _____

Why have you come to see us today (e.g. pain, checkup, etc.)? _____

How did you hear about us? _____

Current Physician (name, location, contact info, and last visit): _____

Today's Date: _____

Personal Contact Information:

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

E-Mail: _____

Please remind me of my next dental appointment via (check all that apply):

Mail E-mail Phone

Social Security Number (Insurance Purposes): _____

Employer: _____ Work Phone #: _____

Emergency Contact Person: _____

Relation: _____ Phone #: _____

Dental Insurance Information

Subscriber's Name: _____

If you are a dependent of the subscriber, please list your name: _____

Subscriber's ID#: _____ Subscriber Birth Date: _____

Group #: _____ Subscriber Phone#: _____

Subscriber's Employer: _____

Insurance Company Name and Address: _____

We require a copy of 2 forms of ID (Drivers License, library card, Credit Card & Dental Insurance Card) for all patients. YOU MUST READ AND SIGN ALL PAGES. Thank you.

Today's Date: _____

Dental + Health History (check or circle):

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you brush your teeth? How often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you floss? How often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you having any pain or discomfort at this time? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed while brushing? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed while flossing? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive to hot or cold liquids/foods? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever experienced any of the following problems with your jaw?
If yes, please circle all that apply:
Clicking Pain Difficulty When Opening/Closing Difficulty in Chewing |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have frequent headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you clench or grind your teeth? If yes, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any orthodontic treatment? If yes, do you wear a retainer? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had facial surgery? If so, when and what area of your face?
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any type of trauma to your mouth, jaw or face? If yes, please describe:
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear dentures or partials? If yes, please provide the month and year of placement:
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about bad breath odor? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pleased with the appearance of your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pleased with the color of your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nervous about dental treatment? Anything to make you comfortable? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or have you ever had opioid dependency, drug addiction or other? |

If needed, please provide any additional information regarding your dental health history below or information that may be relevant when planning your dental treatment:

Medical Health History (check or circle):

Are you allergic or have you reacted adversely to any of the following (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa Drugs, Sulfites, Sulfides |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Acetaminophen/Tylenol |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Latex, Metals, Plastic | <input type="checkbox"/> Local Anesthesia (Novocaine or other) |
| <input type="checkbox"/> No Known Drug Allergies | <input type="checkbox"/> Anything else/other? _____ |

Please list any other medical allergies or concerns below:

Today's Date: _____

Check any of the following that you have had or have at the present:

- | | |
|---|--|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Bisphosphonate therapy (e.g. Boniva) |
| <input type="checkbox"/> Heart disease or heart attack | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart murmur/mitral valve prolapse | <input type="checkbox"/> Thyroid issues |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Artificial joints |
| <input type="checkbox"/> History of drug addiction /alcoholism | <input type="checkbox"/> Hypertension (High blood pressure) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS or HIV+ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital heart lesions |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Tuberculosis or lung disease |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sinus issues |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Infectious mononucleosis (mono) |
| <input type="checkbox"/> Herpes (reschedule if present on appt) | <input type="checkbox"/> Sexually transmitted/venereal disease |
| <input type="checkbox"/> Tumor or malignancy | <input type="checkbox"/> Cancer/chemotherapy/radiation |
| <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Implants: Location_____ |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Allergies (including food) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hard of hearing |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sickle cell disease/traits |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> COVID-19 |

Other/anything else: _____

Major surgeries (type and year): _____

List sports activities: _____

Today's Date: _____

Please list all medications or drugs you are currently taking. (Including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements.)

Name of medication	Dosage in MG	Number of times taken	When
<i>i.e. Lisinopril</i>	<i>50</i>	<i>1x</i>	<i>As Needed</i>

Yes No

- Have you been hospitalized during the past two years? Why? _____
- Have you been asked by your medical doctor to pre-medicate before any dental treatment?
- Have you taken Fen-Phen, Redux or appetite suppressants? If yes, have you seen a physician for a cardiac evaluation? _____
- Do you smoke, vape, or use chewing tobacco? Any sugar in Vape? If Yes: Interested in Quitting? Y or N
- Do you smoke or use marijuana? If Yes: What type + when? _____ (reschedule if used today)
- Do you drink alcohol? If yes, how often and in what quantity?
- For males only**, do you take Viagra or equivalent?
- Have you ever taken Fosamax or Boniva?

For Women Only:

Yes No

- Are you pregnant? If yes, due date: _____
- Are you taking birth control pills?
- Could you be pregnant? Are you nursing?
- Are you taking a hormone replacement pill?

Authorization: I confirm that the information on this form is accurate. I understand that this information will be used by the dentist to help determine my dental treatment. If there is any change in my medical status, I will inform the dentist. I certify that I have fully read and understood all of the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any members of their staff responsible for any errors or omissions that I may have made in the completion of this form and understand the HIPAA regulatory laws.

Printed Name: _____

Signed Name: _____ Date: _____

Doctor Signature: _____ Date: _____

Today's Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Full Legal Name: _____

Address: _____ City: _____

Zip Code: _____ Phone #: _____ Social Security #: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes or revisions. Those revisions may apply to any of your health information, which we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Anthony Valentine, D.D.S. Telephone: (734) 662-6772 Fax: (734) 662-6778

Address: 1121 E. Stadium Blvd. Ann Arbor, MI 48104 E-mail: info@valentinedentalcare.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the Consent will not affect any action we took in reliance on the Consent prior to receiving your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected healthcare information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name: _____

Relationship to Patient: _____ Authority: _____

Today's Date: _____

CONSENT FOR COMPOSITE FILLINGS

After completing your exam and X-rays, the doctor may diagnose the need for a filling, or fillings, to help eliminate cavities and improve oral health. A cavity will never go away on its own. There are different types of filling materials that can be used. Two of the most common filling materials are Amalgam and Composite. Below are some facts regarding each. Please note that we are an amalgam free office and only place composite resin fillings:

AMALGAM: *The historic and traditional silver filling material.*

According to the American Dental Association, Amalgam is:

- Metal alloy (silver color) including copper, tin, silver, mercury, and others
- Not a hazard
- Durable for chewing
- Partial to potential sensitivity to cold (metal conducts temperature)
- Less expensive and most insurance companies cover expected percentage.

COMPOSITE: *Tooth colored filling material*

According to the American Dental Association, a Composite is:

- A white colored substance, which bonds to teeth
- Made with a composite of materials including ceramic particles (metal sparing fillings)
- Partial to potential tooth sensitivity (temperature and other)
- Susceptible to needing replacement earlier than amalgam fillings
- May **not** covered, or partially covered by insurance. Therefore, all composite fillings may cost approximately \$45.00 more per tooth (and depending on insurance).

By signing below, I state that I have read this form and have had any questions, answered. I also have researched the information provided and understand that my insurance company may change coverage for filling types.

Printed Patient Name: _____

Patient Signature: _____

Date: _____

CONSENT FOR AUDIO RECORDING

At times, we may record patient conversations for patient treatment related circumstances including but not limited to patient record, laboratory notes, or otherwise. This is purely for your record of your treatment and may be converted to written notes. By signing below, you authorize our office to record and scribe conversations as needed for your dental records.

Patient Signature: _____

Date: _____

Today's Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgment

I, _____, have received a copy this office's Notice of Privacy Practices.

Signature: _____

Date: _____

****FOR OFFICE USE ONLY****

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please Specify)

Doctor Signature: _____ Date: _____

Today's Date: _____

VALENTINE DENTAL CARE, PLLC COMPLETED FORM REQUIRED PRIOR TO TREATMENT INITIATION

FINANCIAL POLICY

We at Valentine Dental Care, PLLC pride ourselves in serving the community providing the finest and most comprehensive dental services possible. Following diagnosis, the doctor will advise you of our plan of treatment. Additionally, we can discuss finances with you per your request- including today's costs and costs of any future treatment plan that were discussed during your visit.

INSURANCE

We are here to help and will process your insurance claims for you. The estimated amount not covered by your insurance is due at the time of treatment and may be paid by one of the options listed below. The estimates are subject to change depending on acceptance and approval by your insurance company or treatment changes; therefore, the amount owed to our office for services is subject to change. Please remember that we are not the insurance company and we can only provide ESTIMATES regarding benefits and coverage. Detailed questions may require you contacting your insurance company or human resource individual. Please contact your insurance company to verify benefit coverage amounts. We are often given the incorrect information or not informed if dental work has been completed or undertaken in another office. It is the patient/guardian responsibility to understand their insurance coverage and pay off the balance if the insurance company has not paid. We require payment in advance of treatment. All unpaid balances are sent to collections 60 days after services rendered.

PAYMENT

Payment is required at or before time of visit for all patients. Payment for today's visit and future visits are due at the time of treatment plans. We are sensitive to the fact that some people may not be able to pay in cash at the time of treatment. For this reason, we have added Care Credit or equivalent as an option for treatment payment in our office. We reserve the right to charge interest in the amount of 3% on any unpaid balances after 60 days or any balance paid with a credit card. See receptionist for payment option details. No American Express. For services rendered to a minor, the adult accompanying the minor, and the parent or guardian with custody will be responsible for the payment. A Patient credit card or cash will be utilized to settle all balances. Please provide your Credit card information below and note that signing gives Valentine Dental Care, PLLC authorization to settle outstanding balances from your account including all minors. Please check one below:

Credit Card We accept (please circle): VISA MasterCard Discover (We do not accept AmEx)
Card# _____ Exp Date: _____ security code: _____

_____ I hereby authorize Valentine Dental Care, PLLC to process payments, to settle/pay my account in full with the information above with 3% surcharge (if credit card is used). I understand that my credit card above will be used to settle all balances on my account and provide authorization by signing below.

Printed Patient Name: _____

Patient Signature: _____ Date: _____

_____ I hereby authorize Valentine Dental Care, PLLC to process payments to settle/pay my account in full by cash or cashier check prior to treatment and understand that estimated balances may be used.

Printed Patient Name: _____

Patient Signature: _____ Date: _____

In the event that your account is placed with a third party collections agency or an attorney, you will be assessed all fees that pertain to this collection process.

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BROKEN APPOINTMENT POLICY

Our office requires a minimum 24 business hour notice, based on Valentine Dental Care hours of operation (weekend and closed days are not included) for cancellation of an appointment. We do not accept voice message cancellations including after hours. There is a \$50.00 per hour charge for appointments, which are cancelled or missed without proper notice. This purely allows staff time to fill schedules with others who are in need of dental care.

Thank you,

Valentine Dental Care, PLLC

By signing below, you acknowledge our Broken Appointment Policy and adhere to the conditions.

Printed Name: _____

Signature: _____

Date: _____

Today's Date: _____

Information About Dental Insurance

Dental insurance benefits can cause a great deal of confusion for some patients. Unlike medical insurance, which often has a set co-pay and/or percentage coverage without a maximum allowance, dental insurance benefits often are based upon a random formula and include a maximum amount of coverage. This below attempts to explain some of the most misunderstood features of a dental plan.

UCR (Usual, Customary, Reasonable)

UCR is the maximum amount your insurance plan will pay for a procedure. It is based upon a percentage formula set by the individual insurance company and is not always based upon actual average dentists' fees in your area. The patient is responsible for the costs above the UCR level.

Preferred Providers

Your plan may encourage you to go to a dentist on its list of preferred providers. Most plans allow you to see any dentist you would like, regardless of whether the dentist is on the list. However, your benefits may be different when you visit an out of network dentist.

Pre-Existing Conditions

Some dental insurance plans do not cover conditions that existed prior to enrollment. One example is a "missing tooth clause," which will not pay for the replacement of a tooth that was missing prior to the beginning of coverage.

Frequency Limitations

Some plans set limits on certain procedures and those procedures may not be covered by your insurance as often as they are dentally necessary. Some common examples include only allowing for sealants once in a lifetime when sealants generally last only 3 — 7 years. Other patients may need dental cleanings more than the two times per year that their plan allows.

Deductibles/Percentage Covered

Most plans have a deductible amount, which the patient pays before any benefits begin. This is a one-time fee each benefit year. In addition, insurance plans set a percentage of costs they will cover for each type of treatment. For example, an insurance company may cover 100% of preventative work (exams, cleanings, etc.), 80% of basic restorations like fillings and 50% of major restorations like crowns.

Yearly Maximums

Almost all plans will have an annual maximum benefit and many times this amount is as low as \$1,000 — \$3,000. Your plan will not pay more than this set amount in any given benefit period (typically a year). Patients are responsible for charges above this maximum.

Treatment Exclusion/Wait Periods

Certain plans will not cover some procedures, such as sealants, implants and orthodontics. Dental plans may also place a waiting period on some procedures. For instance, your plan may require you to wait six months for a crown to be a covered service.

Alternative Treatment

Often dental insurance plans will only cover the least expensive treatment possible. For example, many plans only cover the cost of mercury amalgam silver fillings instead of tooth-colored composite fillings. The insurance company will pay its set UCR for an amalgam filling and the patient will pay the difference between the cost of the amalgam and the cost of a composite filling. Many times the least expensive alternative treatment is not the best choice for optimal dental health. Patients need to choose what is best based upon their needs, not their insurance coverage.

Get The Care You Need

When considering all of this information, it is important to remember that you may need dental care that falls outside of your plan benefits or at a time when you have reached your maximum allowance. In order to avoid future dental complications that could require more extensive (and expensive) treatment later, patients always need to make decisions that are in the best interest of their dental health and seek treatment in a timely fashion.