**VALHALLA DENTAL ASSOCIATES LLP**

**50 Legion Drive**

**Valhalla, New York 10595**

PATIENT INFORMATION

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City & State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician's Name & Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy of Preference (name and number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency contact:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Dental Insurance Company **(if applicable**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for filling out these forms completely. It will enable us to help you more effectively. If you have any questions, at any time, please ask us. We are happy to help. Please continue on the following pages.

**MEDICAL HISTORY**

Give details of any "YES" answer

1- Have you ever been treated for any disorders such as heart condition, heart murmur, high blood pressure, diabetes, asthma, kidney disease or any other prolonged or chronic condition?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2- Have you ever had any illness or condition other than a common cold, virus or flu, such as mono, hepatitis, etc.?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3- Have you ever had: a) Infective Endocarditis ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b) Heart or organ transplant?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c) Prosthetic heart valve?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4- Do you have or have you recently had any evidence of an infection, such as boils, infected wounds, sore throat, or persistent cough?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5- Have you ever been hospitalized?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6- What medications are you taking?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7- Are you allergic to any drugs (penicillin), foods, pollen, materials, etc.?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8-Have you ever had any reaction from any anesthetics?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9- If you are a woman: a) are you pregnant?

b) are you nursing?

c) are you taking birth control pills?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10-Are you presently under the care of a physician?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11-Have you ever had any joint replacement,(hip, knee, etc,) or have you had any pins surgically placed?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12-Do you have any condition not listed above that we should be aware of?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13-Are you presently in good health?

1

Reviewed by Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

Last Dental Visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of this visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give details of any "YES" answer. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1-Are you having pain in any of your teeth?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2-Do you have sensitivity to hot or cold?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3-Do your gums bleed?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4-Have you ever had any illness or complication following any dental treatment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5-Have you ever had prolonged bleeding from injury, tooth extraction, etc.?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6-Is snoring a problem for you or any member of your family?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7-What is your present oral hygiene routine?

a) how often do you brush your teeth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

b) how often do you floss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c) other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8-Do you participate in any sports which may endanger your teeth?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9-Do you smoke?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever smoked?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Remarks

Reviewed by Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_

Your Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_

**COSMETIC DENTISTRY QUESTIONNAIRE**

Circle One

1) Do you want your teeth to be whiter? Yes No

2) Do you want your gums to look better? Yes No

3) Do you want to show more or fewer teeth when you smile? Yes No

4) Do you think you show too much or too little gum when

you smile? Yes No

5) Do you want to have longer or shorter teeth? Yes No

6) Would you prefer wider or narrower teeth? Yes No

7) Do you wish your teeth were shaped or positioned differently? Yes No

8) Does your self-confidence lessen when you smile? Yes No

9) Do you ever try to cover your smile? Yes No

10)When you look in the mirror do you see minor defects in

your gums or in any teeth? Yes No

**TMD SCREENING QUESTIONNAIRE**

1) Do you suffer from frequent headaches? (more than once Yes No

a week)

2) Do you ever have pain, discomfort or other sensations,

such as ringing, roaring, stuffiness, etc around the ears,

temples, neck or cheek? Yes No

3) Does it ever hurt to chew? Yes No

4) Does it ever hurt to open wide, take a big bite or yawn? Yes No

5) Does your jaw ever make popping,cracking or grating noises? Yes No

6) Does your jaw ever lock? Yes No

**Consent for Treatment and Authorization to Use and Release Medical and Dental Information**

**CONSENT FOR GENERAL DENTAL TREATMENT**

I consent to diagnostic procedures and treatment (including techniques) rendered by Valhalla Dental Associates, L.L.P (subsequently referred to as VDA) and to having clinical photographs taken that the dentist(s) in attendance deem necessary for my care. I agree to abide by all the rules and regulations of VDA.

I understand that prior to any diagnostic procedures or treatment (including techniques), or obtaining clinical photographs, I will be advised by the doctor or staff responsible for my care, and that I may ask questions concerning my treatment. I also understand that post-treatment complications including bleeding, pain, swelling, loss of teeth, and loss of implants may be a normal consequence of the treatment rendered. I further understand that I may revoke this consent before such treatment is provided. I understand this consent will remain in force unless I revoke it in writing.

**ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY**

I understand that I am responsible for charges not covered by my insurance plan.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I authorize VDA to release to government agencies, insurance carriers, or others who are financially liable for dental and medical care, all information needed to substantiate payment for such care, and allow others who are representatives thereof to examine and make copies of all records relating to my care and treatment.

**PATIENT CONSENT TO ACCESS AND RELEASE INFORMATION TO AND FROM ELECTRONIC PRESCRIBING MEDICATION HISTORY DATABASE**

I authorize VDA to access all electronic prescribing medication history databases and to release my prescription medication history contained in and sent to an electronic prescribing medication history databases (including but not limited to information related to HIV/AIDS, alcohol or drug use problems/treatment, family planning, genetic diseases, mental health conditions, and sexually transmitted diseases) used by VDA. I understand this history may not be comprehensive and includes medications which have been prescribed to me electronically. It is my responsibility to provide my dentist/ care provider with a complete list of medications I am currently taking. I understand that the purpose of this form is for VDA to be able to access and exchange medication history information with authorized electronic prescribing services from other providers, pharmacies and/or third party pharmacy benefit programs/payors.

By signing this form, I am authorizing the access, use or disclosure of protected health information as indicated above.  I may revoke authorization in this form at any time before the information I have requested is released or is acted upon in reliance of this authorization by providing written notice of revocation as specified in the Notice of Privacy Practices. If the receiving party is not subject to medical information privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. VDA shall not be held liable for any consequences resulting from re-disclosure. I will be provided with a copy of this form. I may request a copy of my health information.

This Consent and Authorization does not expire unless I revoke in writing or upon termination of my treatment relationship with VDA.

By signing this form, I hereby state that I have read and understood it, and that I have been given the opportunity to ask questions I might have, and that all my questions have been answered in a satisfactory manner.

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

HIPAA

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

have received a copy of this office’s Notice of Privacy Practices.

Signature

Date

Optional: You may discuss my dental condition with my Parent/Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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)

**Valhalla Dental Associates, LLP**

**50 Legion Drive**

**Valhalla, N.Y. 10595**

Telephone 914-949-1323

Fax 914-421-0930

Valhalladental.com

**Patient Responsibility Form**

Thank you for choosing Valhalla Dental Associates as your dental providers. The dental services you seek imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. Is someone else (parent,spouse,domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them , as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below/and or receiving dental services for Valhalla Dental Associates you agree to our financial policy.

You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts, or any other patient responsibility indicated by your insurance or full payment for treatment you receive that is not covered by insurance.

The patient is responsible for providing Valhalla Dental Associates with the most correct, active and updated information about their insurance prior to each visit.

Valhalla Dental Associates will bill to the insurance most recently provided by the patient with the assumption it is current. If the information provided by the patient is inaccurate and denied, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies, we do run into timely filing deadlines so providing correct information at the time of service is critical so we can accurately bill the patients insurance. Timely filing means the patients insurance plan may not pay the claim after a certain amount of time after the service.

Patients are responsible for the payment of co-pays at the time of service.

Patients are also responsible for paying any applicable co-insurance, deductibles and and all other procedures or treatment not covered by their insurance plan.

The patient is responsible for knowing what their plan does or does not cover. If the patients has questions about their plan and what services are covered, they should contact their insurance (typically support phone numbers are on the back of your insurance card).

The patients dental insurance policy is a contract between the patient and their dental insurance company or employer. It is the patients responsibility to know if their insurance has specific rules or regulations, such as the need for pre-authorizations and any limits or set clauses or whether the provider participates with your insurance.

1. Insurance coverage is not a guarantee of payment.
2. Benefits given to us by your insurance company is only a "quote of benefits "and not a guarantee of benefits until claims are processed by your insurance company
3. If your insurance company has limitations , you may be liable for charges that exceed the limitations of your coverage.
4. All co-pays **MUST** be paid at time of visit.
5. If you are a minor your parents or guardian need to accompany you to our office before treatment can be rendered

I have read and understood the policies of Valhalla Dental Associates. I agree to these terms and will abide by the regulations set forth by Valhalla Dental Associates.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Responsible Party (if patient is a minor) Date