ENDODONTIC PARTNERS OF WEST ALABAMA
Dr. James V. Mills, Jr., D.M.D., P.C.
Dr. Andrew E. Graves, D.M.D.

Date_____

Please tell us about yourself

Patient's Legal Name:_____ Nickname: _____

Date of Birth:_____ Social Security#: _____

Home #:(__)_____ Cell #:(__)_____ Email Address: _____

Address: _____

City :_____ State:_____ Zip:_____

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Does your family dentist use nitrous oxide (laughing gas) when he/she treats you ? ☐ Yes ☐ No

Do you take a **pre-medication** antibiotic before **every** dental procedure? ☐ Yes ☐ No If yes:

Name of antibiotic:_____ Name of Pharmacy:_____ Phone#:(__)_____

Whom may we thank for referring you?_____Who is your family dentist? _____

Employer Information

Place of Employment:_____ Work #:(__)_____

Employers Address:: _____

City :_____ State:_____ Zip:_____

Responsible Party Information

Responsible Party Legal Name:_____ Date of Birth: _____

Responsible Party Employer: _____ Social Security :_____

Work #:(__)_____ Cell #:(__)_____

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Insurance information

Primary Dental Insurance Company

Insurance Company:_____ Phone #:(___)_____

Policy Holder's Name:_____ Relationship to the Patient: _____

Social Security#: _____ Date of Birth:_____

Place of Employment:_____ Work #:(___)_____

Contract or I.D. #:_____ Group #:_____

Insurance Co. Address: _____

City:_____ State:_____ Zip :_____

Secondary Dental Insurance Company

Insurance Company:_____ Phone #:(___)_____

Policy Holder's Name:_____ Relationship to the Patient: _____

Social Security#: _____ Date of Birth:_____

Place of Employment:_____ Work #:(___)_____

Contract or I.D. #:_____ Group #:_____

Insurance Co. Address:_____

City: _____ State:_____ Zip :_____

We will be happy to file DENTAL insurance claims for you at no extra charge, if the insurance company will also issue a check payable to the dentist. In addition, you must provide our office staff proper information (Dental Insurance Card, Social Security Number, and Date of Birth of the person you are filing insurance under). ***The ESTIMATED difference that the insurance does not pay mu be paid the day of the office visit.***

Medical History

Name:_____ Date of birth:_____

Have you ever had: (check if yes)

- ☐ Heart problems (Heart attack, surgery, valve)
- ☐ High blood pressure
- ☐ Chest pains (Angina)
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Swelling of hand or feet
- ☐ Artificial joint (hip, knee)
- ☐ Blood transfusion
  When ?_____
- ☐ Tuberculosis(TB)
- ☐ Emphysema
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Sinus congestion
- ☐ Shortness of breath
- ☐ Other breathing problems:
- ☐ Kidney infections
- ☐ Venereal disease
- ☐ Herpes
- ☐ Cold sores or fever blisters
- ☐ Frequent sores or ulcers in mouth
- ☐ Bleeding gums
- ☐ Pain in jaw joint (TMJ)
- ☐ AIDS or been exposed to the HIV (AIDS) Virus
- ☐ In a "high risk" group for AIDS
- ☐ Epilepsy
- ☐ Dizzy or fainting spells
- ☐ Seizures
- ☐ Psychiatric treatment
- ☐ Tranquilizing medication
- ☐ Hepatitis
- ☐ Yellow jaundice
- ☐ Liver disease
- ☐ Diabetes
- ☐ Ulcers or stomach problems
- ☐ Thyroid disease
- ☐ Cancer or tumor
- ☐ Surgery or hospitalization in the past two years? Please list them:_____

_____

Are you pregnant? ☐ Yes ☐ No
Do you take birth control pills? ☐ Yes ☐ No
Are you currently under the care of a doctor?
☐ Yes ☐ No
If so for what reason?_____
Name of your Physician:_____

Are you currently taking any prescription medications? ☐ Yes ☐ No
Please list them:_____

Do you have any disease or condition not mentioned above? ☐ Yes ☐ No
If so please explain:_____
Are you **allergic** to any of these:

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Penicillin
- ☐ Latex
- ☐ Other

Antibiotics:_____

- ☐ Novocaine
- ☐ Latex
- ☐ Other medications:_____

Have you ever had a reaction to an injection or medication given to you by your dentist?
☐ Yes ☐ No
Please explain:_____

To the best of my knowledge the above information is accurate and true. If the patient is a minor, I, as the parent/guardian give my permission for any needed dental treatment. I understand that it is my responsibility to inform the dental office of any changes in my medical status, or that of my dependants.
Signature:_____
Date:_____

OVER ▶

ENDODONTIC ASSOCIATES OF WEST ALABAMA
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Office Payment Policy

This is a referral practice, and a mutual respect to obligations is essential to permit our business to be conducted on a efficient and friendly basis. Therefore, to avoid misunderstandings concerning payment of accounts, please note that endodontic treatment is usually completed in one visit and mus be paid in full. We will be happy to file ***DENTAL*** *insurance claims for you at no extra charge, if the insurance company will also issue a check payable to the dentist.* ***In addition, you must provide ou office staff proper information (Dental Insurance Card, Social Security Number, and Date of Birth of the person you are filing insurance under).*** *The* ***ESTIMATED*** *difference that the insurance does not pay must be paid the day of the office visit.*

Your insurance is a contract between you as a subscriber, and the insurance company as insurer, involving our office, only indirectly. Therefore, any controversy which might arise over your insurance company's handling of your claim is for you to resolve. Any discrepancy between the insurance company's allowance and your total indebtedness remains your responsibility. Any insurance claim that has not been paid within 60 days of treatment will be billed back to you.

If your insurance is Blue Cross Blue Shield of Alabama and it is a PPO contract we are a provider, anc your co-pay is due on the day of the service. However, all PPO contracts do not have the same benefits or the same co-pay. You will be responsible for this information.

☐ *I have dental insurance, I will pay my co-pay today.*
☐ *I will pay in full today.*
☐ *I will charge to:*
☐ *MasterCard* ☐ *Visa* ☐ *Discover* ☐ *Carecredit* ☐ *Check* ☐ *Other:*

***** $30.00 service charge on any returned checks *****

I hereby assign, transfer, and set over to (James V. Mills, Jr. D.M.D., P.C.), (Andrew E. Graves, D.M.D) all rights, title and interest to my dental reimbursement benefits under my insurance policy, I authorize the release of any dental information needed to determine these benefits. This authorization shall remain valid until written notice is give by me revoking said authorization. I understand I am financially responsible for all charges for my dependents, or myself whether or not they are covered by insurance. In the unlikely event this account is submitted for collections, I the undersigned agree to pay any and all collection costs and reasonable attorneys fees. Any account over 30 days ***past due*** *will be assessed a monthly billing charge equal to 1 ½% of the unpaid balance. (18% annually)*

*Guarantor Signature:*_____ *Date:*_____

*Witness:*_____ *Date:*_____

ENDODONTIC ASSOCIATES OF WEST ALABAMA
Dr. James V. Mills Jr., D.M.D., P.C.
Dr. Andrew E. Graves, D.M.D.

Medical Records Release Form

I hereby authorize you to release copies of any medical records including x-rays pertaining to my treatment in this office into my keeping for transfer to another office for myself and any minor family member listed below.

_____ _____

Signature *Date*

Name *Date of Birth*

_____ _____

_____ _____

_____ _____

_____ _____

ENDODONTIC ASSOCIATES OF WEST ALABAMA
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, _____, have received a copy of this office' 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*
- ☐ *Communications barriers prohibited obtaining the acknowledgment*
- ☐ *An emergency situation prevented us from obtaining acknowledgment*
- ☐ *Other (Please Specify)*

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Dr. James V. Mills Jr., D.M.D., P.C.

Dr. Andrew E. Graves, D.M.D.

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 April, 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.___ for each page, $___ per hour for staff time to locate and copy 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 Officer: Michelle Elliott

Telephone: 205 633-3636 Fax: 205 633-3672

ENDODONTIC PARTNERS OF WEST ALABAMA

Dr. James V. Mills Jr., D.M.D., P.C.
Dr. Andrew E. Graves, D.M.D.
621 Helen Keller Blvd. Suite 300
Tuscaloosa, Alabama 35404
Telephone (205) 633-3636 Fax (205) 633-3672

ROOT CANAL THERAPY (ENDODONTICS)

Endodontics is the specialty of dentistry involved in the saving of damaged teeth – teeth that have been so badly damaged by decay, fracture, abscess, etc., that normal restorative procedures can no longer be employed. Retaining a tooth by endodontic treatment is a far better solution than extraction of the tooth and filling in the missing space with prosthetic devices. Artificial substitutes do not function as well as natural teeth, nor are they as easy to keep clean. In addition, extraction and replacement is usually more costly than endodontic treatment and filling.

Treatment is usually accomplished in 1 or 2 visits, but endodontics requires a precise and exacting technique and occasionally circumstances may indicate the necessity for additional visits.

We have the means to control pain and discomfort; therefore, you need not be apprehensive or nervous. We shall make every effort to provide for your comfort and well being. While treatment is relatively painless, at times, reactions (i.e. tenderness, or even swelling) can occur. Although these reactions may prolong treatment, they do not necessarily change the chances of success. NOTE: THESE COMPLICATIONS DO NOT OCCUR ROUTINELY!

No tooth will be treated unless there is a very good chance for success. With conventional root canal therapy, we expect a success rate of approximately 95%. If the chances of success are estimated below this average, you will be informed. With proper root canal treatment and subsequent protective care, your tooth can be expected to remain useful and function indefinitely. The proven rate of success is so consistently high that one need not feel that he is taking an unnecessary risk in attempting to save a diseased tooth.

Upon completion of root canal therapy, you may be referred back to your own dentist to restore the crown of the tooth. This appointment should be made as soon as possible. We will be happy to assist you with making any appointments, if you wish.

The following information is related to fees:

1. Fees vary with the difficulty or complexity of treatment. Generally, non-surgical treatment of the front teeth has the lowest fee.
2. Fees, when quoted, remain the same except:
   a) When the appointments are cancelled, resulting in prolonged treatment.
   b) Broken appointments, without proper notification.
3. All fees are payable by completion of treatment. This is a referral practice, and a mutual respect to obligations is essential to permit our business to be conducted on an efficient and friendly basis.
4. Our fee does not include the restoration that may be necessary to maintain the integrity of the crown of the tooth.
5. All dental services are charged to the patient, and as such, you are personally responsible for the payment of your account. We will be happy to assist you with any insurance claim.