SCHOOL OF DENTISTRY

501 S. Preston Street
Louisville, KY 40202
502-852-5096
louisville.edu/dentistry

Welcome to the University of Louisville School of Dentistry (ULSD)! Thank you for the trust you have placed in us by asking for a new patient evaluation appointment. Providing dental education through hands-on, patient-centered care is a large part of our mission. We appreciate that you want to be part of helping us achieve this goal.

We will mail you an appointment card with the date and time for your new patient evaluation appointment. You can also call us at 502-852-5096 for this information. Please arrive 30 minutes before your appointment time. This will allow you enough time to park, check in, and complete new patient paperwork before your appointment begins.

The new patient evaluation appointment takes about 90 minutes. The purpose of the appointment is to assess your dental needs – including any health concerns – to determine whether our educational programs are a good fit for your needs. Please be aware that making that determination may take extra time if we need to get additional information from your medical doctor(s) first. It is possible that dental treatment will not begin immediately (except in emergency cases).

Additional information to help you prepare for your appointment follows in this letter. We recommend that you bring this letter with you to your appointment in case you need any of the information included. We look forward to seeing you!

Initial Fees

The amount due at the new patient evaluation appointment is $75. This amount covers the cost of one panoramic X-ray. If you do not become a patient at ULSD, the $75 is not refundable. However, you may request a copy of the panoramic X-ray image to take to any other provider. We accept cash, Visa, MasterCard, Discover, and American Express payment for the first visit. We cannot accept checks.

What to Bring to Your Appointment

In addition to payment for your initial fees, please bring the following items to your new patient evaluation appointment:

- A completed Health History Form (the form is enclosed)
- A list of any medications you are taking
- The name(s) and phone number(s) of your medical doctor(s)

You will complete and sign all other new patient documents electronically on the day of your appointment. If you want to view these documents before your appointment, go to **louisville.edu/dentistry/new-patient-packet** or view the attachments in this packet.

If you need to send us any X-rays or radiographs, please do so BEFORE your appointment. We prefer high-quality digital images, but we do accept film-based images. Digital images can be emailed to DentalCA@louisville.edu. Film-based images can be faxed to 502-852-3618 or mailed to: Records Room, School of Dentistry, University of Louisville, 501 S. Preston St., Louisville, KY 40202. If you have questions about sending images, call our Records Room at 502-852-5117.

Accessibility and Accommodations

ULSD is handicapped accessible. There are a limited number of parking spaces by the entryway for those requiring accommodations. Please be sure to have a decal on display, as you can be fined $200 if one is not present. If you need wheelchair assistance, translation services, or any other special accommodations, please call us before your appointment.

How to Contact Us

If you have questions or need to reschedule your appointment, call 502-852-5096. Our normal business hours are 8:30 a.m. to 5 p.m. Monday through Friday. Phones are answered from 8:30 a.m. to 4:30 p.m. **For after-hours dental emergencies for existing patients of record**, the dental resident on call may be reached through the University Hospital operator at 502-562-3000. Please inform the operator that you are a patient of record of the School of Dentistry with a dental emergency. Please be aware that our doctors cannot diagnose dental conditions, prescribe medications, or answer general questions over the phone. If you feel that your condition requires immediate attention, you may also seek assistance at any emergency room.

What Happens After the New Patient Evaluation Appointment

If we determine your dental needs match with a ULSD educational program, we will give you information about the option that meets your needs best. Based on the complexity of your dental needs and your overall medical history, this may be either a student dentist or a graduate/specialty care program. We understand that cost may be a factor in your decision to seek care with us. Please be aware that graduate/specialty care costs more than student dentist care. For all of our educational programs, we accept all major insurances, and an interest-free payment plan is available. If you would like to set up a payment plan, please do so before treatment begins.

Patient/Visitor Entrance Location

The School of Dentistry is located at the corner of E. Muhammad Ali Boulevard and Preston Street. This location is the red building on the map below. Our patient/visitor entrance and drop-off area is noted with a star on the map. **If you are using navigation such as Google or Waze, use this address to navigate to the patient/visitor entrance: 452 E. Muhammad Ali Blvd., Louisville, KY 40202.**

Parking

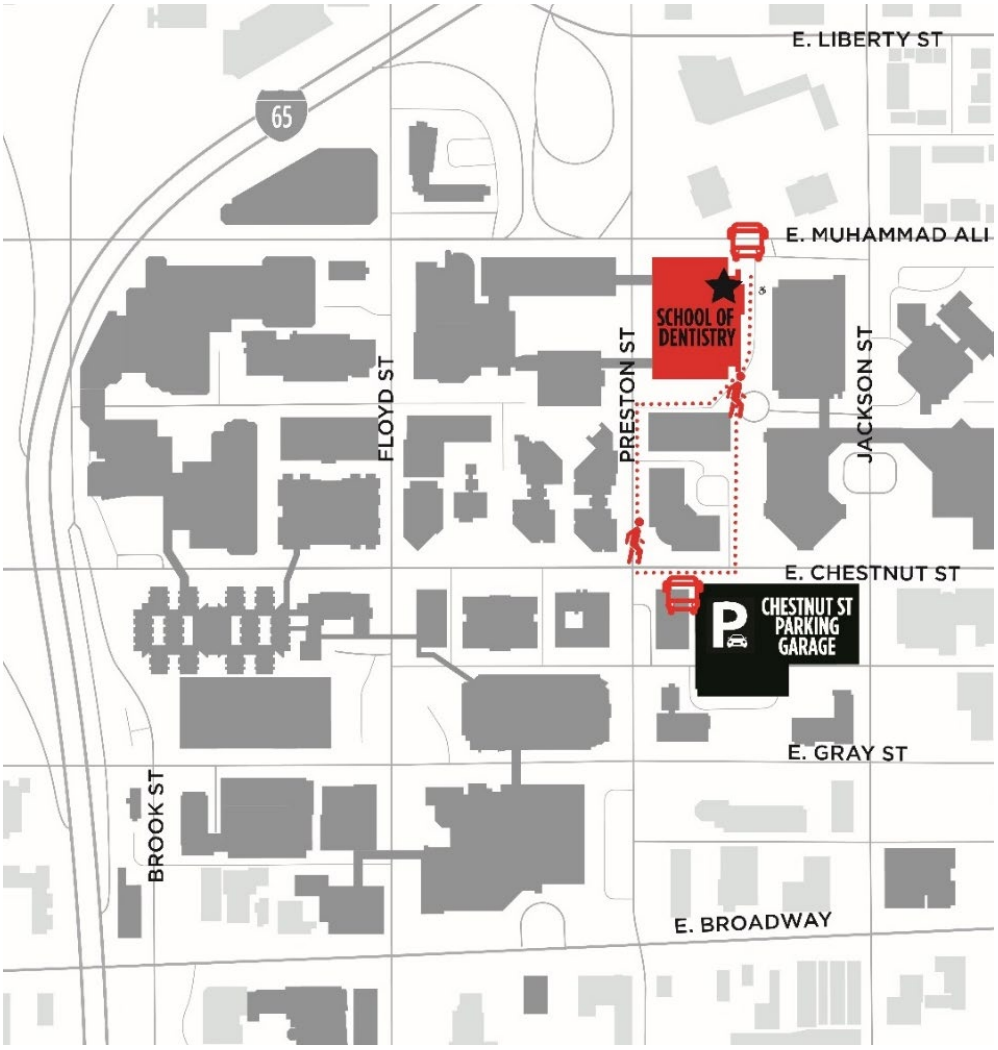
A parking garage is located on Chestnut Street just east of the Preston Street/Chestnut Street intersection. See below for turn-by-turn directions to the garage entrance. On the map below, the garage is the black building; walking paths from the garage to our patient entrance are shown with red dotted lines. If you park in this garage, you may stop by the first floor lobby at ULSD after your appointment to get a voucher for $2 off of the garage parking fee. The voucher is good at the Chestnut Street garage only. It is not valid at the University of Louisville Hospital Garage.

In addition, parking meters are located on the streets near ULSD, including both Muhammad Ali Boulevard and Preston Street. The meters accept payment via credit card, the go502 mobile app, and pay by phone (502-574-6799). They also accept coins. If you choose to park in a metered spot, please make sure you have adequate time on the meter to avoid receiving a ticket. The maximum time is 4 hours, so use of parking meters is not recommended for long visits to the school.

Parking Garage Shuttle

To serve visitors to ULSD who use the Chestnut Street parking garage, the UofL HSC Shuttle stops near the patient/visitor entrance and the garage as part of its regular route. These locations are shown with a red bus on the map below. The UofL shuttle is free and runs approximately every 15 minutes.

Additional information about parking and directions, including a more detailed view of the map below, is available on our website at **louisville.edu/dentistry/parking**.



Turn-by-turn directions to Chestnut Street Parking Garage (414 E. Chestnut St. Louisville, KY 40202)

From the South Via I-65:

- Take I-65 North to Exit 136A (Broadway/Chestnut Street); this ramp exits onto Brook Street
- Continue north on Brook Street for two blocks
- Turn right on E. Chestnut Street
- Continue two blocks
- Parking garage entrance is on the right after you cross Preston Street

From the North Via I-65:

- Take I-65 South to Exit 136C (Jefferson Street Downtown)
- Stay in the far-left lane of the ramp to continue on to Brook Street
- Go one block and then turn right on to E. Market Street
- Go two blocks and turn right on Preston Street
- Continue south on Preston Street for four blocks
- Turn left on E. Chestnut Street
- Parking garage is on the immediate right

From the East or West:

- Take I-64 or I-71 to I-65 South
- Follow the directions from the North Via I-65 Southbound

SCHOOL OF DENTISTRY

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RESPONSIBILITIES

Each patient of the School of Dentistry is expected to:

- Be respectful of others, including the School of Dentistry's providers, staff, and other patients, families and visitors. The School of Dentistry will not tolerate inappropriate language (including discriminatory or harassing comments), violent, angry or disruptive behavior, or threats of harm, from either patients and their family/visitors, or from its providers and staff. The School of Dentistry reserves the right to terminate its provider-patient relationship with patients who exhibit inappropriate behavior. Patients who feel they have witnessed or experienced inappropriate behavior from providers, staff or others at the School should contact the Office of Quality Assurance and Accountability at 502-852-1187 or email dentalqa@louisville.edu.
- Pay for services at each appointment, comply with an established schedule of payment, and/or provide accurate insurance and billing information.
- Come to all scheduled appointments and arrive on time. Patients who arrive 15 minutes or more after the appointment time may be sent away without treatment.
- Maintain good oral health habits between visits and follow the agreed-upon treatment plan, including follow-up instructions. Patients are responsible for outcomes related to their failure to follow the care instructions and treatment plan.
- Inform the School of Dentistry's providers or staff if they have any questions or concerns about their care and treatment.
- Have a parent/guardian present for patients under 18 years of age. Children who accompany adult patients will not be allowed to remain in the treatment cubicle during the appointment period.
- Turn off and put away cell phones while in the treatment cubicle.

NO-SHOW POLICY

The School of Dentistry reserves the right to terminate the provider-patient relationship with patients who have:

- 2 no shows, late arrivals, and/or cancellations with less than 24 hr. notice within a 3-month period.
- 3 no shows, late arrivals, and/or cancellations with less than 24 hr. notice within a 1-year period.

YOUR RIGHTS AS A PATIENT OF THE SCHOOL OF DENTISTRY

1. The School of Dentistry is committed to providing you with appropriate dental care and treatment in a considerate, respectful, and confidential manner, that respects you, your family's values, and your needs, regardless of your race, gender, age, national origin, religion, sexual orientation, or disability.
2. The School of Dentistry strives to provide you with timely dental care within the environment of an academic dental program. As part of the School's educational process and the level of faculty supervision required in the student clinics, appointments may be lengthier than in a private dental practice, and more visits may be required.
3. The School of Dentistry will provide you with information about the approximate cost of the treatment to be rendered prior to the beginning of treatment. You should understand that the fee for services may change before this treatment is completed.
4. You may receive care from various programs throughout the School's clinics. You will receive an explanation of the recommended treatment and any alternate treatment, as applicable, as well as the risks and benefits of the treatment (and what may occur if an existing dental condition is not treated).
   I. You will have the opportunity to be meaningfully involved in the decision-making concerning your treatment at the School of Dentistry, as well as in a discussion of any health-related behaviors and self-management related to that treatment.
   II. The School of Dentistry will provide you with informed consent after your assessment(s) and before treatment begins, unless the circumstances require that emergency care must be provided, or the treatment is being done to develop a treatment plan.
   III. The School of Dentistry strives to make you comfortable in signing an informed consent. You are an important partner in your dental care, and you should ask questions, as needed, so that you can understand the informed consent and the treatment to be provided.

Please note: The School of Dentistry will communicate with its patients in a culturally appropriate manner, in a language and at a level that the patient understands. The School of Dentistry always wants to include patients in the treatment planning process to the level that is comfortable for them.

5. The School of Dentistry will inform you about the health care team (dental student, dental hygiene student, graduate dentist, and/or faculty member) who will be directly responsible for your care, including the names of the team members, and how you may receive assistance in case of a dental emergency.
6. The School of Dentistry will provide you with information regarding continuation of care after completion of the dental treatment.
7. You may withdraw your consent to treatment, and may discontinue participation in the treatment or activity, at any time.
8. You have a right to receive a copy of information found in your dental records. A Federal privacy law, known as HIPAA, grants patients the following rights: the right to request amendments to patient information in some circumstances; the right to request certain restrictions to the use of patient information; the right to request an alternate means of communication; the right to request an accounting of anyone who has used or accessed patient information for any means other than for treatment, payment, and/or healthcare operations; the right to receive the School's Privacy Notice; and the right to make a complaint if patients believe their privacy rights have been violated. Please submit Form 09HIP for Adults, or Form 09aHIP for Minors,
9. If at any time you have a concern or complaint about your rights and responsibilities as outlined above, inappropriate behavior you have experienced or witnessed, the dental treatment being provided by the School of Dentistry, or any of the School's providers, you should contact the Office of Quality Assurance and Accountability, at 502-852-1187 or email dentalqa@louisville.edu.

UNIVERSITY OF LOUISVILLE
SCHOOL OF DENTISTRY

University of Louisville
School of Dentistry
SDP 6 - Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2** for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3** for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4** for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/ privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Special Notes:

- **We do not maintain a directory of patients at the School of Dentistry**
- **University of Louisville School of Dentistry providers and staff are not permitted to communicate with patients through social media or text messages.**
- **This notice is for the UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY. Other separate dental care providers at the University of Louisville and University of Louisville Health also may provide you with health services. You might receive a notice of privacy practices from them, too. If you are seen in a University of Louisville hospital, you will receive a notice that covers medical information gathered during your visit there and which may include the information created by the UNIVERSITY OF LOUISVILLE.**

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: April 14, 2003, revised July 20, 2020 (formatting changes only), revised 09/22/2023 (address change for Privacy Office)

This Notice of Privacy Practices applies to the following organizations:

The University of Louisville School of Dentistry, 501 S. Preston St., Louisville, KY 40202

Website: http://louisville.edu/dentistry Phone: 502-852-5096

University of Louisville Privacy Office, 215 Central Avenue, Suite 205, Louisville, KY 40208
Phone: 502-852-3803 Email: privacy@louisville.edu Website: http://louisville.edu/privacy

SCHOOL OF DENTISTRY

502-852-5096

Screening & Appointments

Emergency Care

Patient Services

Mon-Fri 8:30AM-4:30PM

About the School

The University of Louisville has been providing dental care for over 100 years. It offers a full range of general and specialty dental services to the public.

The School takes pride in the quality of care and personal service it provides to its patients. You will be cared for by professional and friendly personnel who will help you achieve excellent oral health.

Dedicated dental students, dental hygiene students and dental residents provide the majority of treatment, which is supervised and evaluated by our faculty. Your dental care will take a longer period of time; however, you are assured of personal attention and supervision.

To Our Patients…

Patient Care Information

Educating dental practitioners is an important mission of the School. Therefore, patients are accepted for treatment in the student clinics if their treatment needs are appropriate to satisfy educational objectives. Each patient is assigned to a dental student for general dental care. Once a patient is assigned to a comprehensive care group, they are contacted for additional appointments. Upon completion of treatment, patients are appointed for regular cleanings and examinations to keep their teeth and gums healthy.

Your Responsibilities

As a patient, please understand that the School of Dentistry is an educational institution where all students, faculty, staff and patients are accepted regardless of age, race, nationality, gender, reprisal, religious, disability, family, social status, or sexual orientation. It is our responsibility, as well as yours, to treat everyone in the clinic with courtesy and respect.

Please remember: Being a patient of the School of Dentistry may require more visits than private practice. Patients need to be available for a three-hour appointment at least twice a month to be eligible for the DMD program.

*If your dental needs are too complex for the student clinics, you may be referred to an advanced education program, or to private practice to better suit your dental needs.

Emergency Care

All patients are eligible for urgent care at the School of Dentistry.

Emergencies are by appointment or walk-in*.

The ULSD Emergency clinic can be reached at 502-852-5096. Assigned patients may also call their dental student.

For emergency care after 5:00 PM on weekdays, and on weekends and holidays, our patients should call 502-852-5096 for information on how to receive care.

Fees and Insurance

There will be a charge for the services you receive. Patients are required to pay for services at the time treatment is provided.

The School accepts cash, debit cards, all major credit cards (Visa, MasterCard, Discover and American Express) and most dental insurance plans. Our Patient Services staff will assist you in processing your insurance claims. A contractual payment plan can be arranged with a minimal down payment and monthly installments.

Student clinic fees are generally lower than private practice. Treatment is provided with personal attention and supervision; however, students will take significantly longer than a private dental practice.

Location and Parking

The School of Dentistry entrance is located at 452 E. Muhammad Ali Blvd. on the University of Louisville Health Sciences Campus. The School is located on TARC bus lines, providing easy accessibility.

Patient pay parking is located inside the UofL Health Care Outpatient Center parking structure located at 414 E Chestnut St. Limited metered street parking is located on Muhammad Ali, Preston, and Chestnut Streets. The School is handicap accessible, and limited handicapped parking is available near the entrance.

To better serve our patients, the School of Dentistry provides a free shuttle service for pick up and drop off from the Chestnut street parking garage and the School of Dentistry patient entrance. The UofL shuttle runs approximately every 15 minutes. We hope this will assist in your visit to the school!

Advanced Education Programs

Please ask for a one-hour parking voucher from the main entrance receptionist.

Advanced Education Programs

Advanced Education programs are offered at the School of Dentistry to resident dentists. Residents have already graduated from Dental School and are continuing their education in a specialized field. Fees for services provided by resident dentists are generally about 20% less than those in a private dental practice.

Special Patient Situations

The School of Dentistry offers a variety of programs and services to accommodate most patient needs. For patients with complex treatment needs, or for whom time is a concern, care is available at a slightly higher fee in the following Advanced Education Programs:

University of Louisville Dental Associates
502-852-5401.

Endodontics: 502-852-5677

General Practice: 502-852-7660

Oral Surgery: 502-852-7660

Orthodontics: 502-852-5625

Pediatric Dentistry: 502-852-5642

Periodontics: 502-852-5100

Prosthodontics: 502-852-3482

FACULTY PRACTICE

For patients interested in being treated by ULSD Faculty, you may call:

Community Health Clinics and How to Find a Dentist

Sometimes treatment is too complex for dental students to perform or manage. In these cases, patients are referred to private practice. Below are a number of local resources to find a dentist:

Find a Dentist (online)	Community Health Clinics (Reduced Services):

American Dental Association: https://findadentist.ada.org Kentucky Dental Association: www.kyda.org/find-a-dentist.html Indiana Dental Association: http://www.indental.org/Find-a-Dentist	Family Health Centers Portland Dental Office: 502-772-8160

UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY

GENERAL CONSENT FORM - FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

1) I hereby consent to the performance of a course of dental treatment procedures, deemed necessary and desirable for any condition found on examination, or any dental treatment or procedures which may later become apparent during treatment. This consent shall extend to all treatments, services, medications and operations upon the teeth and jaws as may be necessary to correct oral deficiency, abnormality and/or infection. I consent to the administration of anesthetic agents for my dental treatment. I acknowledge that no guarantee or assurance is made as to the results that may be obtained. I further consent that the authorities of this facility may dispose of any tissues or parts which it may be necessary to remove.
2) I hereby consent to treatment by University of Louisville dental and dental hygiene students and/or faculty or staff, in accordance with ordinary practices of the School of Dentistry facilities.
3) I have been asked and agree to the taking of pictures either by x-ray, digital camera and/or by the use of closed-circuit television (including motion pictures). I understand that my photographs, videotapes, digital or other images may be used to assist with my identification, diagnosis and treatment, the payment of my bill, and for educational purposes within the School. Other than for education, treatment, payment and healthcare operations, images that could be used to identify me will NOT be released outside of the School without a signed authorization.
4) I understand that the School uses Standard Precautions (the highest level recommended by the CDC) for infection control protocol. I understand that in the event of an occupational blood exposure to a student/faculty/staff, I may be asked to be tested for COVID-19, Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV).
5) I understand that this facility operates on a *fee-for-service* basis and that fees are payable at the time of service. I understand that the established fees will be charged for services rendered and that quotes and/or estimates of costs for planned treatment are only binding if associated with a signed approved treatment plan that reflects the accurate established fees for the planned procedures. I authorize the School to release any information and records concerning my treatment as may be necessary to process insurance claims or payment for the care and treatment provided. I assign to the School of Dentistry all dental and medical insurance benefits applicable and authorize my insurer or third-party payment program to tender payment of such amounts directly to the School of Dentistry.
6) If I provide a telephone number or email address, I consent to receive calls, text messages, or electronic mail, including, but not limited to, messages about appointments, treatment, billing, and payment for items and services. Messages may be prerecorded or artificial voice messages and may use automatic dialing devices or any other form of electronic or voice communication. I may cancel this consent by notifying the School in writing.
7) Patient Rights: ❑ I have been provided and accept a copy of the University of Louisville School of Dentistry's Patient Rights and Responsibilities. ❑ I declined to take a copy of the Patient Rights offered.
8) Privacy Notice: ❑ I have been provided and accepted the University of Louisville School of Dentistry's Notice of Privacy Practices. ❑ I declined to take a copy of the Notice of Privacy Practices offered.
9) Insurance Benefits: I have provided the University of Louisville School of Dentistry my insurance information so the School may process my insurance claims as a courtesy to me. I understand and agree to pay all co-payments and/or deductibles in accordance with my insurance plan. I also understand that most insurance plans do not pay for all costs connected with my treatment and that it is my responsibility to determine my insurance plan coverage. I understand and agree that I am responsible for ALL dental school charges and professional fees for services and supplies that are not covered by insurance.

❑ No insurance information provided

❑ Kentucky Medicaid participant: I understand that if I agree to treatment not covered by Medicaid, I will be asked to accept financial responsibility for the costs before treatment can begin.

10) I certify that I have read and fully understand the general consent form and understand and accept responsibility for payment of services provided.

SIGNATURE OF PATIENT/PERSONAL REPRESENTATIVE Date

ULSD Representative _____ Date

UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY
APPOINTMENT OF PERSONAL REPRESENTATIVE/INDIVIDUALS INVOLVED IN CARE TO RECEIVE PROTECTED HEALTH INFORMATION

You may rely upon your spouse, relatives or friends from time to time to understand your treatment options, visit your health care providers, acquire prescriptions, get test results, and otherwise be involved in your medical care. However, federal law does not allow us to disclose any of this information to these people unless you appoint them as your "personal representatives."

The School may share medical information about you with your family members, friends or any other persons you tell us who are involved in your dental care or who help pay for your dental care.

These individuals may: (please check all that apply)

□ Make/verify appointments □ Discuss financial matters □ Receive messages

□ Discuss treatment options □ Pick up requested information

□ Bring my minor child to their appointments: *[Generally, minor children must be accompanied by a parent and/or legal guardian. However, children between the ages of 13-17, with a signed treatment plan (tx plan signed by parent/guardian) may continue non-invasive treatment without a parent being present. In an emergency situation, consent for treatment may be granted by phone as time allows.]*

List all individuals who may be involved in your care and/or the care of your minor child. Please note that you can add and/or remove individuals at any time.

Name of individuals	Contact Phone Number

Is someone other than the patient signing this form? □ Yes □ No

If yes, what is the relationship to the patient? _____

I may revoke this appointment at any time. My revocation will NOT affect any actions that have been already taken in reliance on my original appointment.

_____ Date:_____

Patient's Printed Name

_____

Patient's Signature

Patient's Address: _____

_____

_____

Patient Name: _____ DOB: _____/_____/_____
Age:(_____)

What is the reason for your dental visit today?

Have you experienced or had contact with someone with any of the following symptoms: Fever >101.5ºF (38.6ºC), severe headache, muscle pain, weakness, diarrhea, vomiting, abdominal (stomach) pain, lack of appetite?
☐Yes ☐No (Please circle symptoms)

Have you or someone you have had contact with recently traveled outside the United States? ☐Yes ☐No
If yes, where? _____

Are you a Veteran? ☐ Yes ☐ No **Do you wear contacts? ☐ Yes ☐ No**

Are you now under the care of a physician? ☐ Yes ☐ No
Name and address of doctor and list condition(s) you are being treated for:

Have you had a serious illness, operation or been hospitalized overnight or had emergency care in the past 5 years?
☐ Yes ☐ No If yes, what was the illness or problem?

List all drugs, medications of any kind you are taking including any vitamins, natural or herbal preparations and/or diet supplements:

Have you had an orthopedic total (artificial) joint (hip, knee, elbow, finger) replacement? ☐Yes ☐No If yes, date of surgery _____/_____/_____ Have you had any complications? ☐Yes ☐No	
Have you ever taken (or are scheduled to start taking) anti-osteoporosis/bisphosphonate drugs such as Aredia, Zometa, Fosomax, Actonel, Boniva, Reclast, Didronel, Prolia, Xgeva or Skelid? ☐Yes ☐No If yes, date treatment began:_____/_____/_____	
Are you allergic to, or have had a reaction to:	
Local anesthetics (Novocain)? ☐Yes ☐No	Penicillin or other antibiotics? ☐Yes ☐No
Aspirin or ibuprofen (Motrin)? ☐Yes ☐No	Codeine or other narcotics? ☐Yes ☐No
Latex (rubber)? ☐Yes ☐No	Metals (nickel, silver, etc.)? ☐Yes ☐No
Any other drug or medicine (please list):	

Do you need accommodations or have any special needs?

☐ Blind/ Visually impaired ☐ Deaf/ hearing impaired ☐ Require wheelchair	☐ Require American Sign Language (ASL) ☐ Do you need help understanding English? What language do you prefer?

Dentist Name/Phone Number/Address:

_____

_____

_____

Please check to indicate if you have/had any of the following diseases or problems:

Heart attack	☐Yes ☐No	Kidney disease/kidney failure/ dialysis	☐Yes ☐No
Angina/chest pains or exertion	☐Yes ☐No	Asthma	☐Yes ☐No
Heart failure or enlarged heart	☐Yes ☐No	Emphysema or chronic bronchitis	☐Yes ☐No
Arrhythmia/irregular heartbeat	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Endocarditis	☐Yes ☐No	Exposed to anyone with tuberculosis	☐Yes ☐No
Congenital heart defect	☐Yes ☐No	Persistent cough longer than 3 weeks	☐Yes ☐No
Artificial (prosthetic) heart valve	☐Yes ☐No	Cough that produces blood	☐Yes ☐No
Heart pacemaker/defibrillator	☐Yes ☐No	Fever, chills, night sweats	☐Yes ☐No
Heart transplant or surgery	☐Yes ☐No	COPD or shortness of breath	☐Yes ☐No
Stroke or transient ischemic attack	☐Yes ☐No	Pneumonia	☐Yes ☐No
Sinus trouble	☐Yes ☐No	Autoimmune disease/Arthritis	☐Yes ☐No
Seasonal Allergies/Hay Fever	☐Yes ☐No	Cancer/Chemotherapy/Radiation	☐Yes ☐No
Anemia	☐Yes ☐No	Transplant-Organ/bone marrow/stem	☐Yes ☐No
Sickle cell anemia/disease	☐Yes ☐No	Blood transfusion	☐Yes ☐No
Hemophilia or Excessive bleeding	☐Yes ☐No	Anxiety/Depression/Psychiatric	☐Yes ☐No
Tendency to bleed longer than normal	☐Yes ☐No	HIV-positive or AIDS	☐Yes ☐No
Leukemia or lymphoma	☐Yes ☐No	Sexually transmitted disease	☐Yes ☐No
Hypertension/high blood pressure	☐Yes ☐No	Tobacco smoking	☐Yes ☐No
Low blood pressure	☐Yes ☐No	Alcohol or drug addiction	☐Yes ☐No
Rheumatic fever	☐Yes ☐No	Recreational drug use	☐Yes ☐No
Epilepsy, seizures or convulsions	☐Yes ☐No	Dementia/Alzheimer's	☐Yes ☐No
Thyroid disease	☐Yes ☐No	Cerebral palsy	☐Yes ☐No
Diabetes – if yes, your level today?	☐Yes ☐No	Autism/Intellectually challenged	☐Yes ☐No
Stomach or intestinal ulcers	☐Yes ☐No	**WOMEN ONLY:**	
Gastritis or esophageal reflux	☐Yes ☐No	Pregnant?	☐Yes ☐No
Gastrointestinal disease	☐Yes ☐No	Taking birth control pills?	☐Yes ☐No
Hepatitis or yellow jaundice	☐Yes ☐No	Nursing?	☐Yes ☐No
Liver disease or cirrhosis	☐Yes ☐No		

DO YOU HAVE ANY OTHER DISEASE, MEDICAL CONDITION, OR PROBLEM NOT LISTED ON THIS FORM? ☐Yes ☐No If yes, then please list below:

_____

_____

Name/Address/Phone of your Pharmacy:

_____

_____

_____

Weight: _____ Height: _____ BP:_____/_____ HR: _____ 02 Sat:_____