Patient Acknowledgement of

Receipt of Dental Materials Fact Sheet and

Notice of privacy Practices

As of January 1, 2002, the Dental Board of California requires that we distribute to our patients a copy of The Dental Material Fact Sheets. In addition, The Health Insurance Portability and Accountability Act (HIPPA) requires, effective April 14, 2003, that patients be given a copy of our Notice of Privacy Practice.

Please print and sign your name below.

I, _____ , acknowledge that I have received from this office:

1. A copy of the Dental Materials Fact Sheet
2. The Notice of Privacy Practice

_____ _____

Patient's or Parent's or Guardian's signature Date

If sign by a personal representative of the patient, describe the representative's authority to act for patient. _____

_____

ARBITRATION AGREEMENT

Article 1
It is understood that any dispute as to dental/medical malpractice, that is as to whether any dental/medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

Article 2
a) Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "Doctor" as used in the Agreement includes the undersigned Doctor and his or her professional corporation or partnership, all independent contractors who practice dentistry at the undersigned Doctors place of business, and any employees' agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities. The Doctor signing this Agreement signs it on behalf of all the foregoing individuals and entities, intends to bind each of them to arbitration to the full extent permitted by law.

b) Treatment Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Doctors and Patient will be subject to compulsory, binding arbitration.

c) Other Doctors (if Applicable). Patient understands that he or she may at times receive treatment from one or more Doctors who are independent contractors practicing at the same facility as the undersigned Doctor. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such Doctors practicing at the same facility as the undersigned Doctor will be subject to compulsory, binding arbitration.

d) Coverage of Prenatal Claims (if Applicable). Patient understands and agrees that, is Doctor treats her during pregnancy, any dispute of the sort described in Article 1 as to (medical/dental) treatment which is claimed to have affected the unborn child will be subject to compulsory, binding arbitration.

Article 3
a) Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the medical/Dental care rendered by Doctor to Patient, Patient will promptly notify Doctor so that Doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the limitations for 90 days.

b) Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement within 10 days of the expiration of the 90 days, Patient shall notify Doctor in writing of his or her desire to arbitrate and shall designate an arbitrator. Within 20 days of receipt of such notice, Doctor will designate an arbitrator to act on Doctor's behalf. In this event that more than two parties participate, all controversy shall than be submitted to the three arbitrators for a final and binding decision.

c) Applicable law. The arbitration shall be conducted pursuant to the California Arbitration Act. (C.C.P 1280-1295.) The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on merits shall be rendered in accordance with the law of the State of California including the provisions of the medical injury Compensation Reform Act of 1975 which shall apply to the same extent as if the dispute were pending before a superior court of this State.

d) Interpretation of Agreement. Any controversy concerning the interpretation or application of the Agreement itself shall also be submitted to arbitration in the manner provided above.

Article 4
Revocation. If you sign this Agreement and then change your mind, the law permits you to revoke the Agreement, providing you give your Doctor written notice within 30 days from signing that you want to withdraw from the Agreement. However, Doctor and Patient agree that any claim arising from dental/medical services rendered prior to revocation shall be subject to arbitration.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDCIAL/DENTAL MALPRATICE DECIDED BY NEUTRAL ARBITRATION AND YOUR ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient's Name: _____ Date: _____

Signature

X-RAY CONSENT FORM

Patient Name: _____ *Date:* _____

During your examination, the doctor may feel that x-rays/pictures will be needed in order to diagnose your condition. We would like to make you aware that x-rays may be required in order to administer treatment. In order to perform x-rays/pictures on any patient our office requires the patients consent for such tests to be performed.

Please Choose One:

___ *I understand that my doctor may need x-rays/pictures in order to diagnose my condition. I give my permission of all needed diagnostic tests and for such items to be used for purposes of research, education or publication in professional journals.*

___ *I understand that my condition may require my doctor to take x-rays to further diagnose my symptoms. I choose not to have any x-rays/pictures at this time and release my doctor of all liabilities.*

Signature _____ *Date:* _____

Females Only:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that ten (10) days following onset of a menstrual period are generally considered to be safe for x-rays exams.

With those factors in mind, I am advising my doctor that:

I am pregnant	___ *Yes*	___ *No*	___ *I don't know*
I could be pregnant	___ *Yes*	___ *No*	___ *I don't know*

Signature _____ *Date:* _____

HIPAA PRIVACY NOTICE

Effective April 14, 2003

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

Introduction

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures

We can use or disclose your protected health information for purposes of treatment, payment and health care operations.

- Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
- Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance carrier (or other third party payor) information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the carrier or other third party payor for the services rendered to you, we can provide the carrier or other third party payor with information regarding your care if necessary to obtain payment.
- Health Care Operations mean the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective.

Disclosures Related To Communications With You Or Your Family

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or relate specifically to your medical care through our office. For example, we may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the number that you have given us in order to contact you.

We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

We will allow your family and friends to act on your behalf to pick up prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

Other Situations

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report victim of abuse, neglect, or domestic violence
- To report reactions to medications
- To notify people of product, recalls, repairs or replacements
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

Health Oversight Activities. We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in a response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of a criminal conduct
- About criminal conduct on our premises
- In emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Disaster Relief. When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Your Rights

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.
2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.

3. Subject to payment of a reasonable copying charge as provided by state law, you have the right to inspect or obtain a copy of the protected health information contained in your medical and billing records and in any other practice records used by us to make decisions about you, except for:

   - Psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record
   - Information compiled in a reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
   - Protected health information involving laboratory tests when your access is required by law
   - If you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you
   - If we obtained or created protected health information as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research
   - Your protected health information is contained in records kept by a federal agency or contractor when your access is required by law
   - If the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information

   We may also deny a request for access to protected health information if:

   - A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person
   - The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person
   - The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person

   If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request a correction to your protected health information, but we may deny your request for correction, if we determine that the protected health information or record that is the subject of the request:

   - Was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment
   - Is not part of your medical or billing records
   - Is not available for inspection as set forth above
   - Is not accurate and complete

   In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the period provided by law, except for disclosures:

   - To carry out treatment, payment and health care operations as provided above
   - To persons involved in your care or for other notification purposes as provided by law
   - For national security or intelligence purposes as provided by law
   - To correctional institutions or law enforcement officials as provided by law
   - That occurred prior to April 14, 2003
   - That are otherwise not required by law to be included in the accounting

6. You have the right to request and receive a paper copy of this notice from us.

7. The above rights may be exercised only by written communication to us. Any revocation or other modification of consent must be in writing delivered to us.

Complaints

If you believe that your privacy rights have been violated, you should immediately contact our Practice or our Privacy Officer. All complaints must be submitted in writing. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

* You May Refuse to Sign This Acknowledgment*

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

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Patient Registration

Thank you for choosing our office to assist you with your dental needs.
Please fill out the information below and don't forget to provide your signature at the end.

Patient's name _____ Date of Birth _____

Sex:_____

If minor, name of legal guardian_____

Home phone _____ Mobile phone _____ Work phone_____

Email address:_____

Mailing address _____ City _____State _____ Zip _____

Employer _____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your SS# : _____ or Member ID#_____

Dental Insurance Co._____ Group number_____ Claims Address_____

Covered by spouse's insurance? ❑ yes ❑ no Spouse's Name _____

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ SS# or Member ID# _____

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following? (Please check any that apply)

- ❑ **Are you required to Pre-medicate before any dental treatment?**
- ❑ Blood Problems (Anemia)
- ❑ Blood transfusion
- ❑ Heart problems
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Pacemaker
- ❑ Stroke
- ❑ Bone or joint problems
- ❑ Artificial joint or valves
- ❑ High or low blood pressure (circle one)
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis, jaundice or other liver disease
- ❑ Diabetes TYPE 1 or TYPE 2
- ❑ Epilepsy or Neurological disorders
- ❑ Thyroid problems
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Cancer/Tumor
- ❑ Abnormal bleeding after any surgery (heavy bleeder)
- ❑ Hayfever or sinus trouble
- ❑ Allergies
- ❑ Asthma

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners e.g. Coumadin)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin other diabetes drugs
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Natural supplements
- ❑ Other:_____

Women:

- ❑ Are your pregnant or plant to become pregnant
- ❑ Taking hormones or contraceptives

Do you smoke,vape or use tobacco? ❑ yes ❑no

Name of your primary medical physician:_____ Phone number_____

Signature of patient (or parent) _____ Date _____

FINANCIAL AGREEMENT

Payment is due at the time of service unless prior arrangements have been made.

It is our policy to have a definite agreement between you the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment please ask our front desk for an approximate cost **prior** to treatment. For convenience, we accept cash, check, VISA, MasterCard, Discover, American Express, and Care Credit. All emergency dental services or any dental service performed without previous financial arrangements with the office manager must be paid for at the time of service.

PATIENTS NOT COVERED BY DENTAL INSURANCE

Payment is expected when services are rendered. If major dental work is required, it is understood that at least half of the balance will be paid when treatment is started. The remaining balance is due when the treatment is completed. Financial responsibility on the part of each patient will be determined before treatment. Any dental service performed without previous financial arrangement or **verified** dental insurance must be paid for at the time of service.

PATIENTS COVERED BY DENTAL INSURANCE

If you have dental insurance we will be happy to complete the necessary forms for your claim as a courtesy to you. However, your insurance is a contract between you and your insurance company. You are responsible for your entire bill regardless what your insurance company pays. We are a third party providing the service to you. We require that you be responsible for your co-payment and deductible at the time of service. After insurance has been filed and if benefits have not been received within 60 days from your insurance company, the entire balance becomes the patient's responsibility. A refund will be given when the benefits have been received from the insurance company. The office cannot render services in the assumption your charges will be paid by your insurance company. Any balance exceeding 60 days may have a 10% per annum service charge on the unpaid balance. We charge a $10 billing charge for any statement sent 90 days after charges were incurred.

In consideration for the professional service rendered to me or at my request by the doctor, I agree to pay for those services in full. I further agree to pay all cost and reasonable attorney fees if the suit be instituted here under. If your account is turned over to a collection agency and a collection fee of 40% of the account balance will be added and must paid by the patient. I grant my permission to you to telephone me at home or work to discuss matters related to this form. After 2 consecutive missed appointments, it is our policy not to reschedule you for any further appointments. There is a $25.00 charge for all returned checks for which the balance of the check and the return check fee will be paid for in cash or money order only.

We require a 24-hour notice to reschedule or cancel an appointment. This will enable us to serve other patients that may need emergency dental care. There is a $ 35 charge for a missed appointment if notice is not given.

I have read and understand the above financial and office policy agreement. I have read and understand the Notice of Privacy Practice (HIPAA) posted in this office and will receive a copy of these upon my request.

_____ _____

Patient name *Date*

_____ _____

Patient/Legal Guardian Signature *Date*

Rev. 8-13

DENTAL MATERIALS FACT SHEET

	GENERAL DESCRIPTION	PRINCIPAL USES	COST	DURABILITY	APPEARANCE	PATIENT TOLERANCE
PORCELAIN and similar materials	Porcelain, ceramics and glass - like materials.	**CROWNS (caps) AND VENEERS**	**HIGH** Requires at least 2 visits and laboratory services.	**VARIES** May fracture under heavy biting loads.	**EXCELLENT** Looks like the tooth.	**Well tolerated.**
METALS	Alloys of gold or other metals.	**CROWNS AND BRIDGES** Also used for partial dentures.	**HIGH** Requires at least 2 visits and laboratory services.	**EXCELLENT** Very strong and durable.	**POOR** Looks like the metal used.	**Gold alloys are well tolerated.** Very low sensitivity. Other metals sometime cause allergies.
PORCELAIN FUSED TO METAL	Porcelain fused to an underlying metal to add strength.	**CROWNS (caps) and BRIDGES**	**HIGH** Requires at least 2 visits and laboratory services.	**EXCELLENT** Very strong and durable.	**VERY GOOD** Does not quite have the translucency of natural teeth.	**Gold alloys are well tolerated.** Very low sensitivity. Other metals sometime cause allergies.
AMALGAM (Silver Filling)	Mixture of mercury and silver alloy powder forming a solid filling.	**FILLINGS** Especially where not easily seen and the bite is heavy.	**LOW**	**GOOD TO EXCELLENT**	**POOR** Has a silver or blackened silver color..	**Well tolerated.** Very low sensitivity.
COMPOSITE	Mixture of glass filler and acrylic.	**FILLINGS** Which are easily seen.	**MODERATE TO HIGH**	**FAIR** If filling is small or average size.	**GOOD TO EXCELLENT** Looks like the tooth but tends to stain.	**Well tolerated.** Very Low sensitivity.