PATIENT INFORMATION

Child's Name: _____ Nickname: _____
DOB: _____/_____/_____ Age: _____ ◯ Male ◯ Female
Address: _____

Parent/Guardian Information

Parent/Guardian Name: _____ Relationship to Patient: _____
DOB: _____/_____/_____ Email: _____
Home/Cell Phone: _____ 2nd Phone: _____

Parent/Guardian Name: _____ Relationship to Patient: _____
DOB: _____/_____/_____ Email: _____
Home/Cell Phone: _____ 2nd Phone: _____

Insurance Information

Dental Insurance: _____ SSN #/Member ID: _____
Policy Holder's Name/Responsible Party: _____
Employer: _____ Job Title: _____

Secondary Insurance? ◯ Yes ◯ No
Dental Insurance: _____ SSN #/Member ID: _____
Policy Holder's Name/Responsible Party: _____
Employer: _____ Job Title: _____

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have an authorization allowing this person to accompany your child. The person bringing your child will need to present a photo identification at time of service. If you choose to authorize a designated adult to accompany your child to their appointments, please fill out the section below or you can choose not to designate someone at this time.

Authorization for a Designated Adult to Accompany Patient

Name: _____Relationship to Patient: _____
Home/Cell Phone: _____ Email: _____

I authorize the above named to make any dental and medical decisions, including accompanying my child to clinic visits and consent to any changes in the treatment plan as they may arise at the time of the treatment, where the minor is not accompanied by either parents or legal guardians, and may not be feasible or practical to contact them. I agree to pay for my portion of the services provided to my child same day, if any, as the treatment is rendered.

◯ I do not wish to assign a designated adult to accompany my child to appointments at this time.

Parent/Guardian Name: _____ **Patient Name:** _____

Parent/Guardian Signature: _____ **Date:** _____

Bethel Kids DENTAL
531 W. Kettleman Lane, Lodi, CA 95240
1660 W. Yosemite Ave. #1, Manteca, CA 95337
3633 Bradshaw Rd. #A-D, Sacramento, CA 95827

HEALTH HISTORY FORM

Dental History

◯Yes ◯No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____
◯Yes ◯No Has your child experienced any unfavorable reaction from previous dental care? If yes, please explain: _____
◯Yes ◯No Does your child suck a finger, thumb, or pacifier (please circle)? If yes, when? _____
◯Yes ◯No Does your child go to bed with a bottle or sippy cup? If yes, what is in it? _____
◯Yes ◯No Does your child snack frequently? What are their favorite snack foods? _____
◯Yes ◯No Has your child had local anesthetic? If yes, were there any problems? _____
◯Yes ◯No Has your child ever been sedated for dental treatment? If yes were there any problems? _____
◯Yes ◯No Have your child's teeth ever been injured? Which teeth: _____
◯Yes ◯No Has your child or anyone in your immediate family ever had a cold sore or other mouth ulcer? Please describe: _____
◯Yes ◯No Does your child use a fluoride toothpaste?
◯Yes ◯No Does your child begin to smoke cigarettes or use any tobacco products?

Please check if your child is having problems with any of the following:

◯Cavities ◯Color of Teeth ◯Grinding of Teeth ◯Gum Infections ◯Jaw Sounds
◯Mouth Breathing ◯Orthodontics ◯Sensitive Teeth ◯Trauma ◯Toothache
Other: _____

Medical History

Child's Physician/Pediatrician: _____ Phone: _____
◯Yes ◯No Is your child in good health? Date of last physical exam: _____
◯Yes ◯No Has your child ever had a health problem? _____
◯Yes ◯No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain: _____
◯Yes ◯No Is your child currently taking any medications? Please give medication, dose, and reason: _____
◯Yes ◯No Is your child allergic to any medications? Any food? If yes, please list what medication and/or food: _____
◯Yes ◯No Are your child's immunizations current?
◯Yes ◯No Have you ever been told that your child needs to take antibiotics before dental treatment?

Please check if your child has been treated for any of the following:

◯Abuse ◯Cancers/Tumors ◯Heart Murmurs ◯Sickle Cell Disease
◯ADHD ◯Cerebral Palsy ◯Hepatitis ◯Significant Injuries
◯Adverse Drug Reaction ◯Congenital Birth Defect ◯HIV/AIDS ◯Snoring
◯Anemia ◯Diabetes ◯Liver/GI Disease ◯Speech/Hearing Issues
◯Asthma/Breathing Problems ◯Endocrine/Growth Problems ◯Mental Delays ◯Spina Bifida
◯Autism ◯Eyesight Problems ◯Personality Problems ◯Tonsil Problems
◯Blood Transfusion ◯Frequent Infections ◯Recurrent Headaches ◯Tuberculosis
◯Blood Disorders ◯Heart Disease ◯Seizures
Other: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Patient Name: _____

Parent/Guardian Signature: _____ **Date:** _____

INFORMED CONSENT

Exams/X-rays/Fluoride Treatment

For the first visit and periodical exam, we perform comprehensive examinations, take necessary radiographs, and give fluoride treatments to ensure that our patients are in best oral health. The frequency of radiographs being taken depends on patient's oral hygiene and caries risk assessment. I understand that my child will be receiving a dental examination from Dr. Opinga and/or his staff members. I understand that x-rays may be taken of my child's teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

Dental Cleaning

I authorize Dr. Opinga and/or his staff members to clean my child's teeth today.

Drugs and Medication

I understand that antibiotics, analgesics, and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

Medical Photography Consent

I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purposes of identification, submission of insurance claims, and dental treatment.

Optional Photography Consent

I consent to having my child's photo taken and displayed in the office as part of contests or bulletin boards.
◯ I consent ◯ I do not consent

I consent to having my child's photo taken and posted as part of online social media including, but not limited to: the office website and blog; Facebook, Yelp and Instagram.
◯ I consent ◯ I do not consent

Authorization and Release

I hereby certify that I have read and understand the consent form. I affirm that that information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any change in my personal contact information and the medical status of my child. I authorize the dental team to perform the necessary dental service my child need including, but not limited to, examination, prophy, radiographs, and fluoride treatment. I hereby certify that I understand and have been informed of the risks, benefits, and alternatives of the provided dental procedures.

Parent/Guardian Name: _____ **Patient Name:** _____

Parent/Guardian Signature: _____ **Date:** _____

OFFICE POLICIES

Parent/Guardian Policy

I acknowledge that the policy of Bethel Kids Dental is for a legally responsible parent or guardian to be present for all dental appointments. If someone other than the parent or legal guardian accompanies your child to their visit, they must have a signed parental authorization/consent on file, or we reserve the right to reschedule the appointment.

It is not allowed for parents or guardians to leave or abandon their child in the office during dental exam or treatment and be picked up by any ride sharing services at a later time. Unaccompanied children will not be released to anyone who is not the parent or guardian on file. The office will not be responsible for any unaccompanied children and the parent or guardian will waive all liabilities from the office for anything that may happen to the unaccompanied child while in the office without their parent or guardian. We will contact the appropriate local authorities for further instructions if the parent or guardian is unreachable or unavailable after attempt is made by the office to contact the parent or guardian on file.

Cancellation and No Shows

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, we require at least a 24-hour advanced notice. This courtesy makes it possible to give your reserved room to another patient who would like it. Repeated cancellations with a maximum of three missed appointments without notice will result in loss of future appointment privileges. We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We, of course, would appreciate the same courtesy from you. If you have any questions or issues that are preventing you from keeping your appointments, please call us ahead of time at (209) 400-2018 and we will gladly reschedule your appointment to a more convenient time.

Requesting a new BIC or replacement BIC Card (For Medi-cal Dental Insurance)

If you did not receive your card, lost your card, your card was stolen, or the card you received in the mail has the wrong information on it, you may ask for a BIC from your local county social services office. For San Joaquin County, you may call and ask for a Benefit Identification Card (BIC) by contacting the BIC Issuance Desk at 209-468-1328.

HIPAA Notice of Privacy Practices Acknowledgement, Consent, and Authorization

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices. I understand and consent to my child's medical information being used within the guidelines of The Health Insurance Portability and Accountability Act (HIPAA). I understand the terms and authorize Bethel Kids Dental to disclose my child's dental information to practitioners involved in my child's care and parties I authorize to receive my child's dental information.

Dental Materials Fact Sheet

I acknowledge that I have received a copy of the Dental Materials Fact Sheet of May 2004.

Parent/Guardian Name: _____ Patient Name: _____

Parent/Guardian Signature: _____ Date: _____

FINANCIAL POLICIES

Although our office will gladly e-file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility. You are required to provide your most current insurance information prior to every visit and as needed throughout care. Insurance plans can vary greatly, and some companies arbitrarily select certain services that they will not cover. I authorize Bethel Kids Dental to collect payment from the insurance company. I understand that the insurance company may reimburse only a portion of my bill and that I am ultimately responsible for the full payment. If the insurance company denies a claim for any reason at any time, I understand that I am directly responsible for the payment of the outstanding amount. A member of our Billing Department will notify you if there's any unpaid balance in your account. We understand that many can experience financial difficulties at any moment in time. If this is the case, please contact our Billing Department so that we may assist you in making payment arrangements. Bethel Kids Dental accepts Cash or Credit Card payments only. INITIALS: _____

UNPAID/UNCOLLECTED BALANCE

Any unpaid and uncollected balances beyond 90 days will be referred to an outside collection agency after notice of non-payment and balance due is sent. In the event that your account is turned over for collections, the responsible party agrees to pay all additional fees incurred in the collection of the debt. These fees include the balance and any fees associated in collecting the payment and attorney's fees. During this time, we will not be able to see your kids for additional services in our office until the unpaid/uncollected balance is paid or payment arrangements is made. INITIALS: _____

TERMS OF PAYMENT FOR SELF-PAY

In the event that you do not have health insurance, or you know in advance that a specific service will not be covered by your insurance company, you will be responsible for making a payment prior to rendering services during that day at our office. You need to pay the full amount at each visit. INITIALS: _____

ASSIGNMENT OF BENEFITS

In certain circumstances, insurance companies may send a check for services provided by BETHEL KIDS DENTAL directly to the patient. In such cases, the patient agrees to endorse and send such a check to BETHEL KIDS DENTAL. If the patient deposits such a check into a personal account, the patient agrees to send a personal check for the equivalent amount to BETHEL KIDS DENTAL within 10 days of having deposited the check from the insurance carrier. INITIALS: _____

I hereby assign all dental benefits, to include major dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medi-cal Dental, private insurance and any other health/medical plan, to issue payment directly to BETHEL KIDS DENTAL. INITIALS: _____

FOR MEDI-CAL DENTAL INSURANCE PATIENTS

You are required to present a valid Benefit Issuance Card (BIC) at every visit and as needed. If you do not have a BIC card at the time of the visit, you are responsible to request a new or replacement card. If we do not have a valid BIC card or eligibility on file, you will be responsible for any fees that are left unpaid or not paid by Medi-Cal Dental. In the instance that Medi-Cal Dental has not paid within 90 days of filing the claim or paid less than anticipated for care, one of our team members will communicate with you regarding the situation. INITIALS: _____

I assume financial responsibility for all dental treatment and medications provided for my child. I understand that payment is expected on the date services are provided. I have read, understood, and agreed to the above financial policy for payments of rendered service(s) to our office.

Parent/Guardian Name: _____ Patient Name: _____

Parent/Guardian Signature: _____ Date: _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate Medical Malpractice and Other Disputes: It is understood that any dispute as to medical malpractice, that is as to whether any 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.**

It is further understood that any dispute related to or arising from any charges, billings, payments, financing, debt collection, solicitations and/or marketing relating to any medical or dental services offered by or rendered by Bethel Kids Dental will be determined by submission to arbitration as provided pursuant to the terms outlined herein.

Article 2: All Claims Must Be Arbitrated: It is the intention and agreement of the parties that this arbitration agreement shall cover all claims or controversies relating to the matters described in Article 1 above, except claims within the jurisdiction of the Small Claims Court, whether in tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress, or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described in Article 1 may arise out of or in any way relate to treatment or services provided or not provided by Bethel Kids Dental. The undersigned understands and agrees that if the undersigned signs this Contract on behalf of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. The reference to Bethel Kids Dental includes the corporation, and its employees, agents and providers.

Article 3: Class Action Waiver: It is the intention and agreement of the parties that any arbitration brought pursuant to this agreement shall be conducted on an individual basis only, and not on a class, collective, or representative basis. There will be no right or authority for any dispute to be brought, heard or arbitrated as a class, collective, or representative action, or as a member in any purported class, collective, representative proceeding ("Class Action Waiver"). Disputes regarding the validity and enforceability of the Class Action Waiver may be resolved only by a civil court of competent jurisdiction and not by an arbitrator. In any case in which (1) the dispute is filed as a class, collective, or representative action and (2) a civil court of competent jurisdiction finds all or part of the Class Action Waiver unenforceable, the class, collective, and/or representative action to that extent must be litigated in a civil court of competent jurisdiction, but the portion of the Class Action Waiver that is enforceable shall be enforced in arbitration.

Article 4: Procedures and Applicable Law: Patient shall initiate arbitration by serving a Demand for Arbitration on Bethel Kids Dental and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: Bethel Kids Dental, 531 W. Kettleman Lane Lodi, CA 95240. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient and his/her attorney. Patient and Bethel Kids Dental agree that any arbitration hereunder shall be conducted by a single, neutral arbitrator selected by the parties and shall be resolved using the rules of the American Arbitration Association then in effect at the time the requirements are met for a demand for arbitration (located at https://www.adr.org/). (Arbitration, however, shall not be conducted by the American Arbitration Association and shall be conducted by an arbitration agency mutually selected by the parties). Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Civil Code §§ 3333.1 and 3333.2, Code of Civil Procedure §§ 340.5, 667.7, 1281-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1- 9), as in effect from time to time. The parties shall bear their own costs, fees, and expenses along with a pro-rata share of the arbitrator's fees and expenses.

Article 5: Retroactive Effect: Patient intends this Contract to cover services rendered by Bethel Kids Dental not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 6: Severability: If any provision of this Contract is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that this Contract is voluntary and that if I do sign it, I may rescind it only by giving written notice which must be delivered to and received by Western at the address outlined in Article 4 within 30 days of signature. I understand that I have the right to receive a copy of this Contract. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Parent/Guardian Name: _____ **Patient Name:** _____

Parent/Guardian Signature: _____ **Date:** _____

BETHEL KIDS DENTAL'S AGREEMENT TO ARBITRATE

In consideration of the foregoing agreements under this Contract, Western likewise agrees to be bound by the terms set forth in this Contract and to the rules specified in Article 4 above.

A signed copy of this document is to be given to the Patient. The Original is to be filed in Patient's dental chart.

DENTAL MATERIALS FACT SHEET

by the Dental Board of California
1432 Howe Avenue Sacramento, CA 95825
www.dbc.ca.QOv

What About the Safety of Filling Materials? Patient health and the safety of dental treatments are the primary goals of California's dental professionals and the Dental Board of California. The purpose of this fact sheet is to provide you with information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

The Dental Board of California is required by law* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure.

As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

* *Business and Professions Code 1648.10-1648.20*

Allergic Reactions to Dental Materials: Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material.

There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam (silver fillings), porcelain fused to metal, gold alloys, and nickel or cobalt-chrome alloys.

If you suffer from allergies, discuss these potential problems with your dentist before a filling material is chosen.

Toxicity of Dental Materials

Dental Amalgam (Silver): Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproductive toxicity. Mercury may harm the developing brain of a child or fetus.

Dental amalgam (silver) is created by mixing elemental mercury (43-54%) and an alloy powder (46- 57%) composed mainly of silver, tin, and copper. This has caused discussion about the risks of mercury in dental amalgam (silver). Such mercury is emitted in minute amounts as vapor. Some concerns have been raised regarding possible toxicity. Scientific research continues on the safety of dental amalgam. According to the Centers of Disease Control and Prevention, there is scant evidence that the health of the vast majority of people with amalgam is compromised.

The Food and Drug Administration (FDA) and other public health organizations have investigated the safety of amalgam used in dental fillings. The conclusion: no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy. The World Health Organization reached a similar conclusion stating, "Amalgam restorations are safe and cost effective".

A diversity of opinions exists regarding the safety of dental amalgams. Questions have been raised about its safety in pregnant women, children, and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest that otherwise healthy women, children, and diabetics are not at an increased risk from dental amalgams in their mouths. The FDA places no restrictions on the use of dental amalgam.

Composite Resin: Some Composite Resins include Crystalline Silica, which is on the State of California's Proposition 65 list of chemicals known to the state of cause cancer.

It is always a good idea to discuss any dental treatment thoroughly with your dentist.

Dental Materials - Advantages & Disadvantages

DENTAL AMALGAM (SILVER) FILLINGS: Dental amalgam is a self-hardening mixture of silver-tin-copper alloy powder and liquid mercury and is sometimes referred to as silver fillings because of its color. It is often used as a filling material and replacement for broken teeth.

Advantages

- Durable; long lasting
- Wears well; holds up well to the forces of biting
- Relatively inexpensive
- Self -sealing; minimal-to-no shrinkage and resists leakage
- Generally completed in one visit
- Resistance to further decay is high, but can be difficult to find in early stages
- Frequency of repair and replacement is low

Disadvantages

- Refer to "What About the Safety of Filling Materials"
- Gray colored, not tooth colored
- May darken as it corrodes; may stain teeth over time
- Requires removal of some healthy tooth
- In larger amalgam fillings, the remaining tooth may weaken and fracture
- Because metal can conduct hot and cold temperatures, there may be a temporary sensitivity to hot and cold
- Contact with other metals may cause occasional, minute electrical flow

The durability of any dental restoration is influenced not only by the material it is made from, but also by the dentist's technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient's cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, and diet and chewing habits.

COMPOSITE RESIN FILLINGS: Composite fillings are a mixture of powdered glass and plastic resin, sometimes referred to as white, plastic, or tooth-colored fillings. It is used for fillings, inlays, veneers, partial and complete crowns, or to repair portions of broken teeth.

Advantages

- Strong and durable
- Tooth colored
- Single visit for fillings
- Maximum amount of tooth preserved
- Small risk of leakage if bonded only to enamel
- Does not corrode
- Generally holds up well to the forces of biting
- Resistance to further decay is moderate and easy to find
- Frequency of repair or replacement is low to moderate

Disadvantages

- Refer to "What About the Safety of Filling Materials"
- Moderate occurrence of tooth sensitivity; sensitive to dentist's method of application
- Costs more than dental amalgam
- Material shrinks when hardened and could lead to further decay and/or temperature sensitivity
- Requires more than one visit for inlays, veneers, and crowns *May wear faster than dental enamel
- May leak over time when bonded beneath the layer of enamel

GLASS IONOMER CEMENT: Glass ionomer cement is a self-hardening mixture of glass and organic acid. It is tooth-colored and varies in translucency. Glass ionomer Is usually used for small filings, cementing metal and porcelain/metal crowns, liners, and temporary restorations.

Advantages

- Reasonably good esthetics
- May provide some help against decay because it releases fluoride
- Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- Material has low incidence of producing tooth sensitivity Usually completed in one dental visit

Disadvantages

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended for biting surfaces in permanent teeth
- As it ages, this material may become rough and could increase the accumulation of plaque and chance of periodontal disease
- Does not wear well; tends to crack over time and can be dislodged

RESIN-IONOMER CEMENT: Resin ionomer cement is a mixture of glass and resin polymer and organic acid that hardens with exposure to a blue light used in the dental office. It is tooth colored but more translucent that glass ionomer cement. It is most often used for small fillings, cementing metal and porcelain metal crowns and liners.

Advantages

- Very good esthetics
- May provide some help against decay because it releases fluoride
- Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- Good for non-biting surfaces, resistant to leakage
- May be used for short-term primary teeth restorations
- May hold up better than glass ionomer but not as well as composite
- Material has low incidence of producing tooth sensitivity
- Usually completed in one dental visit

Disadvantages

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended to restore the biting surfaces of adults
- Wears faster than composite and amalgam

PORCELAIN (CERAMIC): Porcelain is a glass-like material formed into fillings or crowns using models of the prepared teeth. The material is colored and is used in inlays, tooth-veneers, crowns and fixed bridges.

Advantages

- Very little tooth needs to be removed for use as a veneer; more tooth needs to be removed for a crown because its strength is related to its bulk (size)
- Good resistance to further decay if the restoration fits well
- Is resistant to surface wear but can cause some wear on opposing teeth
- Resists leakage because it can be shaped for a very accurate fit
- The material does not cause tooth sensitivity

Disadvantages

- Material is brittle and can break under biting forces
- May not be recommended for molar teeth
- Higher cost because it requires at least two office visits and laboratory services

NICKEL OR COBALT-CHROME ALLOYS: Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are a dark silver metal color and are used for crowns and fixed bridges and most partial denture frameworks.

Advantages

- Good resistance to further decay if the restoration fits well
- Excellent durability; does not fracture under stress
- Does not corrode in the mouth
- Minimal amount of tooth needs to *be* removed
- Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- Is not tooth colored; alloy is a dark silver metal color
- Conducts heat and cold; may irritate sensitive teeth Can be abrasive to opposing teeth
- High cost; requires at least two office visits and laboratory services Slightly higher wear to opposing teeth

DENTAL BOARD OF CALIFORNIA
1432 Howe Avenue
Sacramento, CA 95825
www.dbc.ca.gov

Published by California Department of Consumers Affairs
05/2004

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you, about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this " Notice will be amended to reflect the changes and we will make the new Notice available upon request We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information, about you may also be disclosed to your family, friends-and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders. including, but not limited to, voicemail messages, email, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you-will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page and the staff time charged will be the current minimum wage including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your hearth information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare Information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore, these are not available). You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on December 7, 2017. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2018, the disclosure period' would start on December 7, 2017 up to May 15, 2018. Disclosures prior to December 7, 2017 do not have to be made available).*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health. information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This, request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision, we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

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