KOBODA DENTAL

JENNIFER H. KIM. DDS ● DAVID A. SWOBODA, DDS

Welcome to Koboda Dental

Thank you for entrusting us with your dental care. We are committed to providing you with the highest quality, state-of-the-art dentistry delivered with gentle care in a comfortable, inviting environment. Your health, comfort, well-being, and satisfaction are of utmost importance to us. We strive to provide our patients with the most positive experience…for every visit. "*We go the extra mile for a beautiful smile.*" We wish to not only treat a dental problem, but to help better the over-all health and well-being of our patients. To not only prevent dental disease and restore healthy smiles, but to enhance patients' self-esteem and quality of life. To make a meaningful difference in our patients' lives.

Your First Visit

Your initial appointment will take about an hour and a half, and will include:

- An introduction to our office and staff
- A thorough examination and review of your oral health and overall health history, including digital x-rays, intraoral pictures, extraoral and intraoral soft tissue exam, oral cancer screening, periodontal evaluation, and of course, a comprehensive exam of your teeth.
- A careful evaluation of your current dental status and concerns
- A discussion of different treatment options as well as the best treatment plan to meet your oral health goals.

To facilitate being seen at the time of your appointment, we kindly ask that you complete the attached registration, medical history, and dental history forms prior to your appointment. Please sign, date, and fill out all 4 pages completely, and bring them with you to your appointment.

Your Future Appointments

We believe every patient should understand the status of their dental condition and what is required to restore their mouth to optimum health. The personalized treatment plan from your initial visit, which best addresses your unique needs and concerns, will tell us where we are going, approximately how long it will take to get there, and what the investment will be. In other words, you will know what to expect at each appointment…before the appointment.

Insurance and Payment

We accept all major insurance plans. For your convenience, we accept Mastercard, VISA, Discover, American Express, Bank Debit Cards, and Personal Checks. We also offer flexible, INTEREST-FREE, payment plans through third party financing companies. Your dental insurance is a contract between you and your insurance carrier. We will be happy to assist you with processing your insurance claims. However, your dental insurance carrier may pay less than the actual bill for services rendered, and you are ultimately responsible for payment in full.

Emergencies

We are available for emergency care. If an emergency situation should arise, please call us as early in the morning as possible so that we may better accommodate you. We will take immediate steps to relieve any discomfort you may experience, even after hours.

Appointment Times to Fit Your Busy Schedule

For your convenience, we offer early morning, lunchtime, evening, and Saturday appointments.

We look forward to seeing you. For more information, please visit our website: www.kobodadental.com

Sincerely,

Dr. Jennifer H. Kim, Dr. David A. Swoboda, and Staff
"A smile is for a lifetime. We are dedicated to helping you maintain yours."

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PATIENT REGISTRATION

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name _____ M.I. _____ Last Name _____

☐ Male ☐ Female **I prefer to be called** _____ Date of Birth _____ Age _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Address _____ City _____ State _____ Zip _____

Home (_____)_____ Work (_____)_____ Cell (_____)_____

Best phone number to reach you ☐ Home ☐ Work ☐ Cell **Best time to call you** ☐ Morning ☐ Afternoon ☐ Evening

Email _____ Soc. Sec. # _____ Driver's Lic. # _____

Employer/ School (If student) _____ Occupation _____ Number of years at current job _____

PERSON TO CONTACT IN CASE OF EMERGENCY (Someone NOT living with you)

Name _____ Relationship _____

Home (_____)_____ Work (_____)_____ Cell (_____)_____

WHOM MAY WE THANK FOR REFERRING YOU? _____ Relationship _____

Or How did you hear about our practice? ☐ Drive-By Location ☐ Website ☐ Yellow Pages ☐ Mailer _____ ☐ Other _____

RESPONSIBLE PARTY

Person responsible for this account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home (_____)_____ Work (_____)_____ Cell (_____)_____

Email _____ Is this person currently a patient in our office? ☐ Yes ☐ No

Date of Birth _____ Soc. Sec. # _____ Driver's Lic. # _____

Employer _____ Occupation _____ Number of years at current job _____

For your convenience, we offer the following methods of payment. Please check the option you prefer:

☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ Discover ☐ I am interested in financing options

PRIMARY DENTAL INSURANCE

Name of Insured _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home (_____)_____ Work (_____)_____ Cell (_____)_____

Date of Birth _____ Soc. Sec. # _____ Driver's Lic. # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Employer's Phone (_____)_____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group/ Policy/ ID # _____ Ins. Co. Phone (_____)_____

Insurance Co. Address _____ City _____ State _____ Zip _____

SECONDARY DENTAL INSURANCE

Name of Insured _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home (_____)_____ Work (_____)_____ Cell (_____)_____

Date of Birth _____ Soc. Sec. # _____ Driver's Lic. # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Employer's Phone (_____)_____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group/ Policy/ ID # _____ Ins. Co. Phone (_____)_____

Insurance Co. Address _____ City _____ State _____ Zip _____

RELEASE, ASSIGNMENT, AND SIGNATURE ON FILE

I authorize release of any information concerning my (or my child's) health care, diagnosis, and treatment to consulting health care professionals and insurance claim administrators.

I authorize payment of insurance benefits directly to **Koboda Dental**. I understand that my dental insurance carrier may pay less than the actual bill for services, and that I am financially responsible for payment in full.

I attest to the accuracy of the information on this page.

Patient or Authorized Person's Signature _____ **Date** _____

KOBODA DENTAL

JENNIFER H. KIM. DDS ● DAVID A. SWOBODA, DDS

MEDICAL HISTORY

Initials _____ **Date** _____

To our patients: Because health conditions and medications can have significant interactions with the dental care you will be receiving, we ask that you answer the following questions to your best knowledge. This information is critical to providing appropriate care for you. Your answers are for our records only and will be kept confidential.

PHYSICIAN INFORMATION

Name of Physician _____ Type of Physician _____ Phone (_____)_____

Address _____ City _____ State _____ Zip _____

Date of last physical exam _____

Are you currently under the care of a physician? ☐ Yes ☐ No If "yes," for what reason? _____

ALLERGIES

Are you allergic to or have you had any reactions to the following? If "yes," specify type of reaction _____

☐ Latex ☐ Metals (i.e. Nickel, Mercury, etc) ☐ Local Anesthetic ☐ Aspirin ☐ Penicillin ☐ Tetracycline ☐ Other Antibiotics _____

☐ Codeine or Other Narcotics ☐ Sulfa ☐ Barbiturates or Sedatives (i.e. Valium) ☐ Hay Fever/ Seasonal ☐ Other _____

MEDICATIONS

List any **medications**, including prescription and over-the-counter, along with the **corresponding reason** for taking the medication.

MEDICATION:	REASON:	MEDICATION:	REASON:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has a physician or previous dentist recommended that you take antibiotics prior to every dental appointment? ☐ Yes ☐ No

If "yes," for what condition? _____

Name of physician or dentist making this recommendation _____ Phone (_____)_____

Did you take antibiotics 1 hour prior to today's appointment? ☐ Yes ☐ No If "yes," which medication and dosage? _____

Name of Pharmacy _____ Phone (_____)_____

CURRENT & PAST MEDICAL CONDITIONS

Do you <u>currently</u> have or have you ever had in the <u>past</u> any of the following? Please <u>check</u> Y or N. <u>Circle</u> or <u>specify</u> where applicable.

Y / N	Y / N	Y / N
☐ ☐ Bacterial endocarditis	☐ ☐ Congenital heart disease	☐ ☐ Growth problems
☐ ☐ Pacemaker	☐ ☐ Other congenital heart defects	(Specify: _____)
☐ ☐ Artificial heart valves	☐ ☐ Circulatory problems/ Blood disorders	☐ ☐ Cerebral palsy
☐ ☐ Damaged heart valves	(Specify: _____)	☐ ☐ Muscular dystrophy
☐ ☐ Mitral valve prolapse	☐ ☐ Hemophilia	☐ ☐ Diabetes (Circle: Type I or II)
☐ ☐ Heart murmur	☐ ☐ Abnormal bleeding or Clotting problems	☐ ☐ Hypoglycemia
☐ ☐ Cardiovascular disease	☐ ☐ Anemia (Specify: _____)	☐ ☐ Eating disorder
☐ ☐ Low blood pressure	☐ ☐ Autoimmune disease	☐ ☐ Malnutrition
☐ ☐ High blood pressure	(Specify: _____)	☐ ☐ Hypothyroidism
☐ ☐ High cholesterol	☐ ☐ AIDS/ HIV infection	☐ ☐ Hyperthyroidism
☐ ☐ Irregular heart beat/ Arrhythmia	☐ ☐ Systemic lupus erythematosus	☐ ☐ Gastrointestinal problem
☐ ☐ Chest pain/ Angina	☐ ☐ Multiple sclerosis	☐ ☐ Crohn's disease
☐ ☐ Arteriosclerosis	☐ ☐ Bone or Joint disorders	☐ ☐ Heart burn/ Acid reflux/ GERD
☐ ☐ Stroke (When: _____)	(Specify: _____)	☐ ☐ Irritable Bowel Syndrome
☐ ☐ Heart attack (When: _____)	☐ ☐ Rheumatism/ Arthritis	☐ ☐ Ulcers
☐ ☐ Congestive heart failure	☐ ☐ Osteoporosis	☐ ☐ Colitis
☐ ☐ Rheumatic fever/ Scarlet fever	☐ ☐ Birth defects or Genetic disorders	☐ ☐ Gallbladder trouble
☐ ☐ Rheumatic heart disease	☐ ☐ Mental retardation/ Developmental delay	☐ ☐ Kidney problems

Y / N

- ☐ ☐ Liver disease
- ☐ ☐ Jaundice
- ☐ ☐ Hepatitis (Circle: A or B or C)
- ☐ ☐ Herpes/ Fever blisters
- ☐ ☐ Shingles
- ☐ ☐ Skin rash or Hives
- ☐ ☐ Recurrent infections
  (Specify: _____)
- ☐ ☐ Sexually transmitted disease
  (Specify: _____)
- ☐ ☐ Infectious mononucleosis
- ☐ ☐ Respiratory disease
- ☐ ☐ Difficulty breathing/ Shortness of breath
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis/ Chronic cough
- ☐ ☐ Tuberculosis (When: _____)
- ☐ ☐ Emphysema

Y / N

- ☐ ☐ Sinus trouble
- ☐ ☐ Seasonal allergies/ Hay fever
- ☐ ☐ Severe headaches/ Migraines
- ☐ ☐ Swollen neck glands
- ☐ ☐ Swollen feet or ankles
- ☐ ☐ Unexplained recent weight loss
- ☐ ☐ Delay in healing
- ☐ ☐ Bruising easily
- ☐ ☐ Excessive sweating/ Night sweats
- ☐ ☐ Chronic fatigue
- ☐ ☐ Excessive urination
- ☐ ☐ Excessive thirst
- ☐ ☐ Eye disease/ Glaucoma
- ☐ ☐ Contact lenses
- ☐ ☐ Vision impairment
- ☐ ☐ Hearing impairment
- ☐ ☐ Speech impairment

Y / N

- ☐ ☐ Neurological disorders
  (Specify: _____)
- ☐ ☐ Parkinson's disease
- ☐ ☐ Epilepsy
- ☐ ☐ Seizures/ Convulsions
- ☐ ☐ Dizziness/ Fainting
- ☐ ☐ Sleep disorder
- ☐ ☐ Sleep apnea
- ☐ ☐ Alcoholism
- ☐ ☐ Drug abuse
- ☐ ☐ Mental health disorders
  (Specify: _____)
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Alzheimer's disease/ Dementia
- ☐ ☐ Other _____
  _____

GENERAL HEALTH

Have you had a **serious illness**, **operation**, or been **hospitalized** in the past 5 yrs? ☐ Yes ☐ No
If "yes," please explain _____
Have you ever had **blood transfusion**? ☐ Yes ☐ No If "yes," when? _____
Have you ever been diagnosed with **cancer**? ☐ Yes ☐ No If "yes," when? _____ What type? _____
Did you undergo treatment? ☐ Yes ☐ No If "yes," when? _____ What type? ☐ **Surgery** ☐ **Chemotherapy** ☐ **Radiation**
Are you **immunocompromised**? ☐ Yes ☐ No If yes, why? ☐ AIDS ☐ Other immunosuppressive disorder (Specify: _____)
☐ Immunosuppressive medication or treatment (Specify: _____) ☐ Other _____
Is there a **family history** of the following? ☐ Diabetes ☐ Heart Disease ☐ Cancer
Do you consume **alcoholic beverages**? ☐ Yes ☐ No If "yes," how much do you typically drink in a week? _____
Do you smoke or use **tobacco** in any form? ☐ Yes ☐ No If "yes," what? _____ How much do you smoke per day? _____
How interested are you in stopping? ☐ Very ☐ Somewhat ☐ Not Interested
Do you use **controlled substances** or **recreational drugs**? ☐ Yes ☐ No If "yes," what? _____
Have you ever taken the weight loss medication **Phen-Fen** (also known as Redux or Pondimin)? ☐ Yes ☐ No
Are you taking or scheduled to begin taking **bone density medications/ bisphosphonates** (i.e. Fosamax, Actonel, Aredia, Zometa)? ☐ Yes ☐ No
Are you taking any **blood thinners** (i.e. Coumadin/ Warfarin, Plavix, Aspirin, Vitamin E, Ginko Biloba)? ☐ Yes ☐ No
Are you taking any **vitamin**, **herbal supplement**, or **homeopathic remedy**? ☐ Yes ☐ No If "yes," what? _____
Do you have **activity limitations** or **diet limitations**? ☐ Yes ☐ No If "yes," specify _____
Do you have any **metal rods**, **pins**, **joint replacements**, or **implants** (i.e. orthopedic or cosmetic)? ☐ Yes ☐ No If "yes," when placed? _____
What type? _____
Is there anything else we should know about your health (i.e. other diseases, conditions, or problems not listed)? _____
_____
Have you ever had an unusual reaction to any dental treatment? ☐ Yes ☐ No If "yes," explain _____

FOR WOMEN ONLY

Are you taking the following? ☐ **Birth control pills** ☐ **Hormone replacement**
Are you **pregnant** - OR - is there a possibility you may be pregnant? ☐ Yes ☐ No
If pregnant, how many months? _____ Expected delivery date _____ Are you **nursing**? ☐ Yes ☐ No
Note for women: Antibiotics (i.e. Penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above. The above questions have been accurately answered to the best of my knowledge. I understand the importance of a truthful health history, and that my dental care provider will rely on this information for treating me. I understand that this information will be held in the strictest confidence. I understand that it is my responsibility to inform this office of any changes in my medical health. I will not hold the dentist, or any member of his/ her staff, responsible for any actions they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient or Authorized Person's Signature _____ **Date** _____
Dentist's Signature _____ **Date** _____

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DENTAL HISTORY

To our patients: In order to properly address your concerns and better serve your needs, please answer the following.

PATIENT INFORMATION

Reason for today's visit _____

Do you have any questions or areas of concern? ☐ Yes ☐ No If "yes," specify _____

Are you currently having discomfort? ☐ Yes ☐ No If "yes," **when did symptoms begin?** _____

Describe type: ☐ dull ☐ sharp ☐ throbbing/ pulsating **Describe frequency & duration:** ☐ on & off, transient ☐ continuous, lingering

Is there anything that you would like for us to know about you before your first visit? _____

When discussing treatment, which do you prefer? ☐ An overview of the main points ☐ A very detailed explanation

PREVIOUS DENTIST & DENTAL TREATMENT

Name of Previous Dentist _____ Phone (_____)_____

Address _____ City _____ State _____ Zip _____

Date of last dental **exam** _____ Date of last dental **x-rays** _____ Date of last dental **cleaning** _____

How often do you get your teeth cleaned at the dental office? ☐ Every 3 months ☐ Every 4 months ☐ Every 6 months ☐ Other _____

Have you ever had an unusual reaction, complication, or problem with previous dental **treatment** or dental **anesthesia**? ☐ Yes ☐ No

If "yes," explain _____

What prompted you to leave your previous dental office? ☐ Insurance changed ☐ Moved ☐ Other _____

What is most important to you in a dentist and/ or dental office? _____

HOME CARE & DIETARY HABITS

How often do you eat (including snacks) per day? _____ times

How many sweetened drinks (regular sodas, fruit juices, coffee with sugar, etc.) do you consume per day? _____

Is your home water supply fluoridated? ☐ Yes ☐ No What type of water do you drink? ☐ Bottled or filtered water ☐ Tap water

What type of toothbrush do you use? ☐ Manual ☐ Electric How often do you **brush**? _____ How often do you **floss**? _____

Do you have difficulty cleaning or caring for your teeth? ☐ Yes ☐ No If "yes," specify _____

DENTAL HISTORY

Is there a family history of early tooth loss/ periodontal disease? ☐ Yes ☐ No

Have you ever been told that you have gum disease or need "deep cleaning" ? ☐ Yes ☐ No Have you received treatment? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No Have you ever been told you have "TMJ" problems? ☐ Yes ☐ No

Did you ever have a splint or night guard made for you? ☐ Yes ☐ No Do you wear it? ☐ Regularly ☐ Occasionally ☐ Never

Have you ever had an injury to your head or mouth? ☐ Yes ☐ No If "yes," explain _____

Do you participate in sport activities? ☐ Yes ☐ No Did you ever have a sport mouth guard made for you? ☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment? ☐ Yes ☐ No If "yes," when? _____ Do you wear a retainer? ☐ Yes ☐ No

Do you wear dentures or partials? ☐ Yes ☐ No If "yes," how old are they? _____ years

Are you happy with the way they look? ☐ Yes ☐ No Are you happy with the way they fit? ☐ Yes ☐ No

Do you feel anxious or nervous about seeing the dentist? ☐ Yes ☐ No

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

Y / N	Y / N	Y / N
☐ ☐ Dry mouth	☐ ☐ Swelling in or around mouth, face, or neck	☐ ☐ Loose, shifted, or tipped teeth
☐ ☐ Bad breath	☐ ☐ Jaw pain or sore jaw muscles	☐ ☐ Mouth breathing
☐ ☐ Food or floss getting caught between teeth	☐ ☐ Difficulty opening or closing	☐ ☐ Sensitivity to cold or hot food/ liquid
☐ ☐ Bleeding, tender, or swollen gums	☐ ☐ Teeth grinding or clenching	☐ ☐ Sensitivity to sweets
☐ ☐ Blisters, sores, or growths in mouth	☐ ☐ Frequent headaches	☐ ☐ Sensitivity to biting or chewing/ pressure

HOW DO YOU FEEL ABOUT YOUR SMILE?

Would you like your teeth to be **whiter?** ☐ Yes ☐ No **Which do you prefer?** ☐ Hollywood perfect teeth ☐ Natural look with pleasing irregularities

If you could **change** something about your smile, what would it be? ☐ Size ☐ Shape ☐ Length ☐ Position /Spacing ☐ Other _____

Are there old fillings or dental work you don't like looking at? ☐ Yes ☐ No If "yes," explain _____

How healthy do you want your mouth to be? ☐ Pain relief/ Repairs only ☐ Average ☐ The best it can be

I certify that the above information is complete and accurate to the best of my knowledge.
I give my informed consent and authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

Patient or Authorized Person's Signature _____ **Date** _____

Dentist's Signature _____ **Date** _____

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FINANCIAL POLICY

At Koboda Dental, we believe it is important not only to provide the highest quality dental care using the best material and technology available in the market today, but to make this type of care affordable for our patients. Please let us know if you have any questions or concerns. We are glad to be of assistance, and are committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health.

Estimate of Treatment: We do our best to estimate what your out-of-pocket investment will be. Please keep in mind this is only an estimate. The estimate may change due to changes in necessary treatment and/or changes in insurance coverage.

For our patients with dental insurance: We require payment in full on the day of service for any uncovered portion, co-payment, and/or deductible. As a courtesy, we will help you process your insurance claims upon verification of insurance eligibility, and will accept assignment of benefits from your insurance company. Please note that insurance companies do not guarantee benefits until claims are processed. Upon processing, your insurance company will send you an Explanation of Benefits (EOB) detailing your eligibility and benefits. As your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between YOU and YOUR insurance company. Our office is not a part of that contract. You are ultimately responsible for payment in full for all services rendered regardless of any insurance company's arbitrary determination of coverage.

For our patients without dental insurance: If you do not have insurance or we cannot verify insurance eligibility, payment is due in full at the time of treatment.

Payment Options: Our office accepts Cash, Check, MasterCard, Visa, American Express, and Discover. We also offer an interest-free payment plan (6 monthly payments with NO interest) as well as extended payment plans with interest (with payment options of 24, 36, and 60 months) through third party financing companies.

48-hour Notice Requirement: When you schedule an appointment with us, we reserve the time exclusively for your care. As a courtesy, we usually contact our patients to remind them of their appointments. We understand that circumstances may arise that may prevent you from keeping your appointment. However, we kindly ask that you give our office at least a 48- hour notice from your appointed time. Otherwise, this will be considered a broken appointment, and our office will charge a fee ($75.00 per half hour of reserved appointment time).

I understand the financial policy, and I am aware that I am fully responsible for all charges, including non-payment by my insurance company. If payment is not made as agreed in the above terms, it may cause the account to be referred to an outside collection agency as well as the credit bureau, which may negatively impact my credit. I agree to notify Koboda Dental in the event of any change in address, telephone number, employment, or insurance coverage.

Patient's Name _____

Patient's Signature _____ Date _____

For your convenience, we will keep your credit card information on file.

Name on Card: _____

Card Number: _____ Circle Type: Visa/ MasterCard/ American Express/Discover

Expiration Date (Month/Year): _____ Security Code (on back of card): _____

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Notice of Privacy Practices (HIPAA)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of November 5, 2007 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information.

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-025
Toll Free: 1-877-696-6775

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Acknowledgement of Receipt of Privacy Practice Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices (***please refer to previous page***). The document is not a contract, authorization, release or consent form. This document will remain in your records.

I,_____(Patient/ Legal Guardian), acknowledge that I have received a copy of the Notice of Privacy Practices as required by law.

Patient's/Guardian's Signature_____ Date_____

Dental Materials Facts Sheet

The DMFS can be viewed at the following website: www.dbc.ca.gov/formspubs/pub_dmfs2004.pdf

I,_____(Patient/ Legal Guardian), acknowledge that I have received or have had the opportunity to view a copy of the Dental Material Facts Sheet (DMFS) as required by law.

Patient's/Guardian's Signature_____ Date_____

Consent for X-rays, Exam, and Cleaning

X-rays: I understand that a thorough exam usually requires x-rays, and I consent to having x-rays taken. I understand that only those x-rays that are absolutely necessary for proper treatment will be taken, and that all measures for radiation protection and safety will be adhered to. Insurance companies often place restrictions on now frequently they will pay for x-rays. These limits are general and do not take into consideration each patient's individual needs. Therefore, on occasion, I may be responsible for the cost of x-rays which are very necessary for your individual dental care, but which your insurance company may not cover.

Exam: I understand that after a thorough examination, the dentist will explain findings, treatment options, alternatives, associated risks/benefits, and an estimate of my cost, and I will be given the opportunity to ask any questions that I may have either on the day of my initial appointment or at a subsequent consultation appointment.

Cleaning: I understand that the type of cleaning required will depend on my periodontal health and that the dentist will make the appropriate recommendations. I consent to having my cleaning performed on the day of my exam or at a follow-up appointment.

Patient's/Guardian's Signature_____ Date_____