Surf City Dentist
Ken Yabuki, D.D.S.
Jeff Coleman, D.D.S.
www.surfcitydentist.com

DENTAL HISTORY

Name:_____ **Today's Date** _____
Appt. Date _____

Welcome! Please complete this dental history form so that we may provide you with the best possible dental care.
All information is completely confidential.

☐ **Fragrance Free** ☐ **Out of Network Verified** **Referred By:** _____

Name _____ Date of Birth _____ Email _____
Address _____ City _____ State _____ Zip _____

What is the reason for your visit today? _____
Insured (if not pt) _____ Employer _____ DOB _____ SS# _____
Insurance Co. _____ Group # _____ Member ID _____
Address _____ City _____ State _____ Zip _____
Previous Dentist Name & Number _____
Date of Last Dental Visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

How frequently do you have a dental examination? _____
How often do you brush your teeth? _____ How often do you floss? _____
Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No
What other dental aids do you use (Interplak, toothpick, Waterpik, etc.)? _____
Do you have any dental problems now? ☐ Yes ☐ No
If yes, please describe: _____

Are you seeking information or interested in hearing about any of the following:

Teeth Whitening?	☐ **Yes**	☐ **No**
Cosmetic Dentistry (veneers, full mouth reconstruction, etc)?	☐ **Yes**	☐ **No**
Restorative treatment options (Crowns, Implants, Dentures, etc.)?	☐ **Yes**	☐ **No**
Removable treatment options (Implant supported dentures, All-on-Four, etc.)?	☐ **Yes**	☐ **No**
Snoring and Obstructive Sleep Apnea treatment options?	☐ **Yes**	☐ **No**
Orthodontic Treatment (braces, Invisalign, etc)?	☐ **Yes**	☐ **No**

Are any of your teeth sensitive to:

Hot or cold?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No
Biting or chewing?	☐ Yes	☐ No
Have you noticed any mouth odors or bad taste?	☐ Yes	☐ No
Do you frequently get cold sores, blisters or any other oral lesions?	☐ Yes	☐ No
Do your gums bleed or hurt?	☐ Yes	☐ No
Have your parents experienced gum disease or tooth loss?	☐ Yes	☐ No
Have you noticed any loose teeth or change in your bite?	☐ Yes	☐ No
Does food tend to become caught in between your teeth?	☐ Yes	☐ No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	☐ Yes	☐ No
Bite your lips or cheeks regularly?	☐ Yes	☐ No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?	☐ Yes	☐ No
Mouth breathe while awake or asleep?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No
Snore or have any other sleeping disorders?	☐ Yes	☐ No
Smoke/chew tobacco or other tobacco products?	☐ Yes	☐ No

Have you ever had:

Orthodontic treatment?	☐ Yes	☐ No
Oral surgery?	☐ Yes	☐ No
Periodontal surgery?	☐ Yes	☐ No
Your teeth ground or bite adjusted?	☐ Yes	☐ No
An occlusal guard, night guard or mouth guard?	☐ Yes	☐ No
A serious injury to the mouth or head?	☐ Yes	☐ No

If yes, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	☐ Yes	☐ No
Pain (joint, ear, side of face)?	☐ Yes	☐ No
Difficulty in opening or closing the mouth?	☐ Yes	☐ No
Difficulty in chewing on either side of the mouth?	☐ Yes	☐ No
Headaches, neck aches, or shoulder aches?	☐ Yes	☐ No
Sore muscles (neck, shoulders)?	☐ Yes	☐ No
Are you satisfied with your teeth's appearance?	☐ Yes	☐ No
Would you like to keep all of your teeth all of your life?	☐ Yes	☐ No
Do you feel nervous about having dental treatment?	☐ Yes	☐ No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience?	☐ Yes	☐ No

If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe _____

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MEDICAL HISTORY

Todays Date _____

Name _____ Marital Status _____ Sex _____ Date of Birth _____
Email _____
Address _____ Home/Cell Phone _____
Street City Zip
Work Phone _____
Former Dentist _____ How Long? _____
Name Phone
Physician _____
Name Address Phone
Referred By: _____ Reason: _____
Employed By: _____ Occupation: _____

1. Have you had any medical care or surgeries within the past two years?..... ☐ Yes ☐ No
   Describe _____
2. Are you currently **taking any medication, drugs, pills, or herbal remedies**, including regular dosages of aspirin? ☐ Yes ☐ No
   If Yes, please list:_____
   _____
3. Do you use Tobacco/Nicotine in any form? ☐ Smoke ☐ Chewing ☐ E-cigs/Vape ☐ Other Form ☐ Yes ☐ No
4. Have you ever taken bone loss prevention drugs such as **Fosamax, Actonel, Boniva,** or other similar drugs?..... ☐ Yes ☐ No
5. Have you **EVER had an ADVERSE or ALLERGIC reaction** to any substance or medication?..... ☐ Yes ☐ No
   If Yes, please specify _____
6. Have you ever been diagnosed and/or treated for Sleep Apnea? ☐ Yes ☐ No
7. Do you have any of the following symptoms? ☐ Daytime Sleepiness ☐ Snoring ☐ Waking Gasping for Air
8. Indicate **which** of the following **you have had**, or **have at present**. Check "Yes" or "No" to each item:

Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Hepatitis A, B, C	☐ Yes	☐ No
			Thyroid Problems	☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
Congenital Heart Problems	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Difficulty Swallowing	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Hemophilia/Bleeding Disorder	☐ Yes	☐ No
Pacemaker/Defibrillator	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Cortisone Medication	☐ Yes	☐ No	Hay Fever/Allergy/Hives	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Latex Sensitivity/Allergy	☐ Yes	☐ No	Alzheimers or Dementia	☐ Yes	☐ No
Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
			Radiation Therapy	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No
Arthritis/Joint Pain	☐ Yes	☐ No	Tumors/Cancer	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Organ Transplant	☐ Yes	☐ No	Autoimmune Disease	☐ Yes	☐ No			

9. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
   If Yes, please specify _____
10. Women: Are you Pregnant or think you could be pregnant? ☐ Yes, ___ Months ☐ No Nursing? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medications.

Patient/Guardian Signature _____ Date _____
Comments:

Provider Signature _____ Date _____

OFFICE FINANCIAL POLICY

Thank you for choosing us as your family's dental health care provider. We are committed to providing your family with ideal treatment. It is our goal for patients to clearly understand their treatment needs and financial responsibilities. The following is a statement of our financial policy which we require you read, agree to, and sign; prior to any treatment. This financial policy applies to all services rendered by the doctor or dental hygienists.

In order to avoid any misunderstandings, we would like to make you aware of our financial policy:

- Due to the high demand for appointments ***a <u>48-hour business day notice</u> is required to cancel any office appointment.*** *This must be done with a member of our staff and not by text, email or answering machine. Failure to give our office 48-hour business day notice may result in a minimum charge of $75.00.*
- Payment is expected in full for each visit.
- We accept payment in cash, check, or credit card (Master Card/Visa/Discover)
- We also offer a financing plan called "***Care Credit".***
- All other financial arrangements must be made in writing.
- There will be a charge for returned checks.

If you have Dental Insurance

It is our policy that the patient, rather than the insurance company, is responsible for the complete payment of our services. Your insurance policy is a contract between you, your employer, and your insurance company. We are not party to that contract. Our relationship is with you, not your insurance company. As a courtesy to our patients, we will accept assignment of insurance benefits. All patients with insurance coverage are responsible for payment of non-covered services, any deductible amount not previously met and any co-payment due, at the time services are rendered. We will bill your insurance when you have supplied us with all of the necessary information required to process your claim.

In order to avoid any misunderstandings, we would like to make you aware of our insurance policy

- If your insurance company has not paid our office within 45 days from the time of service, you will be required to pay the balance in full by one of the payment options stated above. Any balance over 60 days will accrue a 1.5% finance charge and any account past due over 90 days is subject to legal proceedings. All necessary collection charges will be the responsibility of the patient.
- We are **not an HMO provider**. We ask that the patient be aware of their plan and its coverage **prior** to their appointment.
- We are a Delta Dental PPO and Premiere provider but we are considered an **out-of-network** provider with all other insurance companies.
- Our estimate of the insurance coverage is not a guarantee of what the insurance company will pay.

If there are any questions concerning these policies, please ask.

I,_____/_____ have read and understand the financial policy.
Signature **Date**

(Print Name)_____ **S.S.#**_____-_____-_____

Jeff Coleman, D.D.S. Inc. & Ken Yabuki, D.D. S. Inc.
18800 Main Street Suite 210 *Huntington Beach, CA 92648 * (714) 847-7733 * fax (714) 842-3072
office@surfcitydentist.com

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www.surfcitydentist.com

SLEEP EVALUATION

Todays Date _____

Name _____

Date of Birth _____ Gender: M____ F____ Height:_____ Weight:_____

Please check any of the following you may have:		
☐ Diabetes	☐ Bruxims (teeth grinding)	☐ Erectile Dysfunction
☐ Stroke	☐ Obese (BMI >30)	☐ Frequent Urination at Night
☐ Depression	☐ Hypertension (High Blood Pressure)	☐ Morning Headaches
☐ Gerd (Acid Reflux)	☐ Snoring	☐ Waking, Choking, Gasping for Air

Please check YES of NO to the following questions:		
1. Do you snore or have you been told that you snore?	☐ YES	☐ NO
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐ YES	☐ NO
3. Has anyone observed you stop breathing or gasp for air during your sleep?	☐ YES	☐ NO
4. Do you have or are you being treated for high blood pressure?	☐ YES	☐ NO

If you answered YES to 2 or more of the above, please continue:

Epworth Sleepiness Scale	Never Doze Off	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
How likely are you to get sleepy or doze off during the following activities:				
1. While sitting and reading?	☐ 0	☐ 1	☐ 2	☐ 3
2. While watching TV?	☐ 0	☐ 1	☐ 2	☐ 3
3. While sitting inactive in a public place?	☐ 0	☐ 1	☐ 2	☐ 3
4. As a passenger in a car for an hour without a break?	☐ 0	☐ 1	☐ 2	☐ 3
5. Lying down to rest in the afternoon?	☐ 0	☐ 1	☐ 2	☐ 3
6. Sitting and talking to someone?	☐ 0	☐ 1	☐ 2	☐ 3
7. Sitting quietly after lunch without alcohol?	☐ 0	☐ 1	☐ 2	☐ 3
8. In a car while stopped for a few minutes at a traffic light?	☐ 0	☐ 1	☐ 2	☐ 3

Total Score: ____

0-5 = Normal Daytime Sleepiness
6-10 = Higher Normal Daytime Sleepiness
11-15 = Mild to Moderate Risk
16-Higher = Severe Risk

Have you ever been diagnosed with Sleep Apnea?	☐ YES	☐ NO
Are you currently using CPAP (or any other apnea/snoring device)?	☐ YES	☐ NO
Are you currently taking any sleeping aids (prescribed or OTC)?	☐ YES	☐ NO
Are you aware of clenching or grinding your teeth?	☐ YES	☐ NO

Patient/Guardian Signature _____ Date _____

Comments:

Provider Signature _____ Date _____

Why We Ask You to Confirm Your Appointment

We get it—you never miss an appointment. Once you've scheduled, you're committed to it.

But life gets in the way and even the best laid plans are forgotten, including the important dental check-up. This is why Surf City Dentist uses a patient reminder system providing a convenient and simple tool to help you remember your next dental visit. To ensure you're properly confirming your appointment, and why we ask you to do so, keep reading.

How our patient reminder system works:

1. You will receive a text or email notification to "Add to Calendar" one hour after your appointment is made.

2. Courtesy Reminder: One month prior to your appointment you will receive a text or email reminder that you have reserved an appointment in our office. If the time is **NOT** convenient, please call our office right away to reschedule your appointment. If you have new dental insurance, Please call the office so that we may verify your eligibility prior to your appointment.

3. Appointment Confirmation: One week before your appointment, you will receive a text message, email, or phone call asking you to confirm that you plan on attending your upcoming visit.
   a) To confirm, **you must respond** to the prompt in either the text message, email, or by calling the office.
   - By text, simply reply with the letter C
   - Via email, click on the "Confirm" button and your appointment is saved.

   b) On the day of your confirmed appointment, you will receive a courtesy reminder three hours before the appointment time.

4. **If the appointment remains "unconfirmed" 48 hours prior to the scheduled time, it is canceled and removed from the calendar.**
   This policy allows Surf City Dentist to treat as many patients as possible that are in need of dental care. Utilizing this system allows us to accommodate all patients waiting for an appointment.

   We value each of our patients and believe this process benefits everyone. Your cooperation in this matter is greatly appreciated.

Please prioritize your communication preferences below:

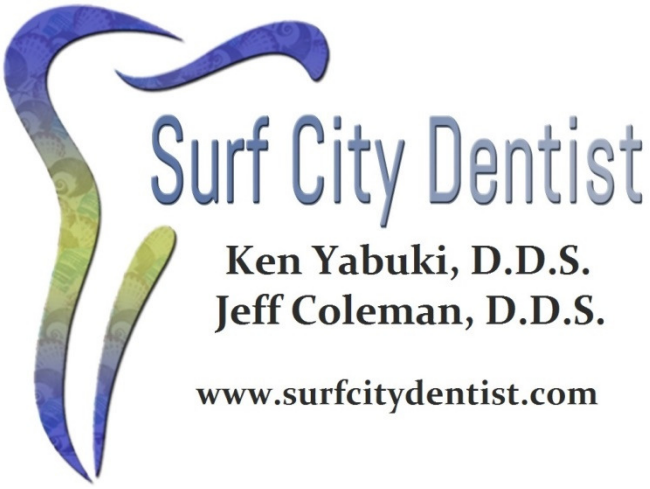
☐ Text _(_____)_____

☐ Email _____

☐ Phone Call _(_____)_____

Signature:_____ Date:_____

Print Name:_____



Patient Acknowledgment of Receipt of Dental Materials Fact Sheet and Notice of Privacy Practices

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Heath Insurance Portability and Accountability Act (HIPAA) requires effective April 14, 2003 that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below.

I _____, acknowledge I have received from this office:

1. A copy of the Dental Materials Fact Sheet; and
2. Notice of Privacy Practices.

_____ _____

Patient Signature or Personal Representative Date

If signed by a Personal Representative of the Patient, describe the representative's authority to act for the patient.

_____
_____
_____
_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

We provide this notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1995 (HIPAA)

* This **NOTICE OF PRIVACY PRACTICES** describes the privacy policies and procedures we adhere to and extends to all healthcare providers and dental office employees for:

Ken Yabuki, DDS
18800 MAIN ST., STE 210
HUNTINGTON BEACH, CA 92648 (714)847-7733

ABOUT YOUR
PROTECTED HEALTH INFORMATION (PHI):

- PHI includes any individually identifiable health information transmitted or maintained by our office in any form or medium (electronically, on paper or orally).
- PHI is protected by law and provides penalties for healthcare providers that misuse or disclose it to unauthorized persons.
- Employment records maintained by a covered entity in its capacity as an employer are excluded from the definition of PH.

The protection of your PHI is something our dental office takes very seriously.

ABOUT THIS
NOTICE OF PRIVACY PRACTICES: (NOTICE)

We are required by law to:

- Give you a copy of this **NOTICE** when you sign a Patient Consent Form.
- Post the Notice in a prominent place and on our Website, if we have one.
- Make the Notice available to patients upon request.
- Provide you with a "revised" Notice, if we make material changes to our Notice and will do so at your next office visit after the changes to the Notice have been made.
- Follow the policies and conditions of the Notice that is currently in effect.

We reserve the right to:

- Change our Notice at any time.
- Make revisions and changes to our Notice effective for PHI already in our system as well as for PHI we obtain from our patients in subsequent visits.

ABOUT USES AND DISCLOSURES OF <u>YOUR</u> PHI:

We may use and disclose your PHI:

- **<u>For TREATMENT</u>**: Means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. For example, we may use PHI we receive from your previous dentist to help determine a treatment plan for your current care.
- **<u>For PAYMENT</u>**: Means such activities as obtaining reimbursement for dental services, billing or collection activities, confirming insurance coverage. For example, we may use and disclose your PHI to obtain payment for dental treatment.
- **<u>For HEALTHCARE OPERATIONS</u>**: Include the business aspects of running our practice, such as conducting quality assessment and improvement activities, employee training, auditing functions, cost-management analysis, and customer service. For example, we might hire a dental consultant to review our scheduling procedures. We may disclose PHI for treatment and payment activities of other covered entity or a health care provider, and for certain health care operations of another covered entity.
- **<u>When REQUIRED BY THE FEDERAL, STATE OR LOCAL LAW</u>**: When requires by the U.S. Department of Health and Human Services as part of an investigation or determination of facilities compliance with relevant laws.
- **<u>TO YOUR FAMILY & FRIENDS</u>: <u>If you agree</u>**, we may disclose your PHI to a family member, friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare. For example, if another person was paying for your dental treatment, you might ask us to explain the treatment to that person.
- **<u>PERSONS INVOLVED IN YOUR CARE</u>:** Unless you object, we may disclose to a member of the family, a close friend or any other person you identify, your PHI as it relates to the person's involvement in your healthcare. If you are unable to agree or object to disclose, we may disclose such information as necessary if we determine that is in your best interest based on our professional judgment. We may use or disclose your PHI to assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death.
- **<u>APPOINTMENT REMINDERS AND OTHER USES</u>:** Your PHI may be used to remind you by phone, computer, or mail of a dental appointment. For example, we may leave a message containing PHI on your answering machine. Or, we may include PHI on recall cards sent to your home or mail you information regarding alternative dental treatment options or related services. We will send you recall notices.
- **<u>MARKETING/SOCIAL MEDIA</u>:** We will not disclose your PHI for marketing communications without written authorization. Our practice may not mention or discuss patient treatment or other information about patients on any social media outlet unless written authorized consent is provided by said patient and the privacy officer. Practice workforce may not engage with a patient's post on a third-part website unless authorized to do so by the privacy officer.
- **<u>EMERGENCY SITUATIONS</u>:** To assist in disaster relief efforts or during a medical emergency.
- **<u>RESEARCH</u>:** To researchers when their research has been approved by an institutional review board that has reviewed the research proposal and protocols to ensure the privacy of your PHI.
- **<u>PUBLIC HEALTH AGENCIES:</u>** To report disease, injury, vital events and to conduct public health surveillance, investigation and or intervention. To a health oversight agency for oversight activities authorized by law including audits, investigations, inspections, licensure and/or accreditation or disciplinary actions, administrative and/or legal proceedings. To prevent or lessen a serious threat to the health or safety of another person or the public and as authorized by laws relating to workers' compensation or similar programs. To the coroner, medical examiner or funeral director, to an organ donations and procurement organization if you are a donor.
- **<u>LAWSUITS, DISPUTES, INVESTIGATIONS AND GOVERNMENT ACTIVITIES</u>:** We may disclose your PHI if required to do so by a court order, administrative order, subpoena or discovery request by you or

another individual involved in the dispute and in the course of certain judicial or administrative proceedings and to federal officials for the intelligence and national security activities authorized by law.

- **LAW ENFORCEMENT**: To law enforcement agencies or for specialized governmental functions. For example, for the identification of victims of a crime, to identification of victims of a crime, to identify or locate a suspect, material witness, missing person, fugitive, or in response to a court order, warrant, summons or subpoena.
- **MILITARY:** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities to do so.
- **INMATES:** If you are an inmate of a correctional institution and if the institution is going to provide care for you. Or, to protect the health and safety of the inmate or others or to protect the health and safety of the institution.
- **FOOD AND DRUG ADMINISTRATION:** (FDA) Covered entities may disclose PHI, without authorization, to a person subject to the jurisdiction of the FDA for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products, and defects or problems with FDA-regulated products.
- **ANY OTHER USES:** Will be made **only** with your written authorization.

ABOUT PATIENT RIGHTS:

As a patient **YOU** have the right to:

- Obtain a copy of this notice, even if you agreed to accept it electronically.
- Request that we communicate with you in a particular manner or at a certain location. For example, you may request we contact you only at home by phone and not by fax machine.
- Confidentiality.
    - Restrict how your PHI is used or disclosed and to whom we may disclose it.
        - Requests to restrict and limit PHI must be in writing;
        - We are not required to agree to your request.
        - **We will** abide by the written consent form you sign and by local, state and federal law.

You have the right to:

- Request an "accounting of Disclosures of your PHI" for yourself or persons you have the legal guardianship over.
- Request Form available at front desk.

REQUESTS MUST BE IN WRITING AND INCLUDE:

- The form of disclosure is requested in. For Example, photocopies or disk.
- A time period (not more than six years back and not before April 14, 2003)
- How you want to be contacted once the request is fulfilled.

WE MAY CHARGE A FEE FOR REQUESTS:

- A fee will be estimated and communicated to you prior to fulfilling your request.
- You may accept or reject your request at that time.

PATIENTS HAVE THE RIGHT TO PROVIDE AUTHORIZATION FOR <u>OTHER</u> USES AND DISCLOSURES:

- Our practice will obtain your written authorization for uses and disclosures that are not identified by this **<u>NOTICE OR PERMITTED BY APPLICABLE LAW</u>**. For example, we may ask for authorization to use your name or other PHI in an advertisement about our practice.
- You have the right to **<u>revoke</u>**, at any time and in writing, any authorization you provide us regarding the use and disclosure of your PHI.
- After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.
- Please Note: We are required by law to retain records of your care.

PATIENTS HAVE THE RIGHT TO ACCESS, INSPECT AND/OR COPY PHI:

- Including medical and billing records for themselves and persons under their custodial or legal guardianship (with proof of that legal relationship)
- Information contained in a "designated record set", medical billing and any other records that we use to help make decisions about your healthcare.
- Access must be provided within five (5) working days of receipt of written request.
- Photocopies must be provided within ten (10) working days of receipt of written request.
- Under federal law <u>you may not</u> inspect or copy:
    1. Psychotherapy notes;
    2. information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding;
    3. PHI that is subject to law that prohibits access to PHI.
    - In some circumstance, you have the right to have the decision to deny reviewed.

PHI may be requested in a format other than photocopies;

- Requests must be in writing. (Ask for a Form at the front desk)
- Or, make a request by letter addressed to our Office Privacy Contact Person (OCP) at the address on the front of this <u>NOTICE</u>.

A cost-based fee may be charged for this service:

- $.20 per copy will be charged for photocopies;
- Plus $15.00 per hour for employee time to locate and duplicate data;
- Plus postage, if you want your health information mailed to you.
- Fees for this service are due at time of delivery of copies.
- PHI requested in a format other than photocopies will be provided on a cost-based fee and a case-by-case basis. (Cost of tape, disk, etc., plus labor) For details see OCP.

We may, in limited circumstances, deny your request to inspect and copy.

- You have the right to challenge our denial.
- A patient challenge to denial will be presented to a dentist (or committee) other than the Dentist issuing the denial, for review. After a review, a finding and decision will be made. Our office will abide by the decision of the Dentist making the review.

Patients have the right to Request PHI be Amended:

- If you believe your PHI is wrong or incomplete.
- This right extends too you for the period of time our office maintains your PHI.
- Request forms available at the front desk.
- **Requests to Amend PHI if:**
    - A reason that supports why you believe the PHI is incorrect/incomplete
    - The date
    - Your signature
- **We may deny your request to Amend PHI if:**

1. You fail to submit the Request in writing
2. And/or fail to include a reason to support the request;
3. If the information you asked to amend was not created by us, unless the person or entity that created the information is no longer available to make amendment;
4. The information you requested is not part of your PHI kept by our office, or not information which you would be permitted to inspect and copy; or the PHI information is inaccurate and incomplete.

ABOUT COMPLAINTS

Patients have the right to complain:

- If you feel that your privacy rights have been violated, you have the right to file a formal, written complaint with us at the address on the front of the NOTICE , or with the DHS, Office of Civil Rights.
- Complaints to us will be turned over immediately to our Privacy Officer, the owner of the dental practice.
- Complaints must be in writing.
- Complaints forms available at the front desk.
- All complaints shall be investigated thoroughly by our Privacy Officer.
- **You may not be penalized for making a complaint.**

Address Complaints To:
Our Dental Practice
Attention: Privacy Officer
At address on the front of this NOTICE

And/or: DHS
U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
(877)696-6775 (toll-free)

Dear Patient,

Thank you for allowing us the privilege of providing your dental care. The security of your protected health information is an obligation and duty every member of our dental team takes very seriously. You have our pledge to be worthy of your trust.

Sincerely,

The Dental Team

Dental Materials – Advantages & Disadvantages

PORCELAIN FUSED TO METAL

This type of porcelain is a glass-like material that is "enameled" on top of metal shells. It is tooth-colored and is used for crowns and fixed bridges

Advantages

- Good resistance to further decay if the restoration fits well
- Very durable, due to metal substructure
- The material does not cause tooth sensitivity
- Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- More tooth must be removed (than for porcelain) for the metal substructure
- Higher cost because it requires at least two office visits and laboratory services

GOLD ALLOY

Gold alloy is a gold-colored mixture of gold, copper, and other metals and is used mainly for crowns and fixed bridges and some 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
- Wears well; does not cause excessive wear to opposing teeth
- Resists leakage because it can be shaped for a very accurate fit

Disadvantages

- Is not tooth colored; alloy is yellow
- Conducts heat and cold; may irritate sensitive teeth
- High cost; requires at least two office visits and laboratory services

DENTAL BOARD OF CALIFORNIA
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The Facts About Fillings

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Dental Materials Fact Sheet

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, 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.

PORCELAIN (CERAMIC)

Porcelain is a glass-like material formed into fillings or crowns using models of the prepared teeth. The material is tooth-colored and is used in inlays, 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

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 fillings, 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 than 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
- May be used for short-term primary teeth restorations
- May hold up better than glass ionomer but not as well as composite
- Good resistance to leakage
- 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

Toxicity of Dental Materials

Dental Amalgam

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 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. 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 for 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 to cause cancer.

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

DENTAL AMALGAM 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
- Generally completed in one visit
- Self-sealing; minimal-to-no shrinkage and resists leakage
- 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
- Resists breaking
- 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 depending on product used
- 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