Sonrisas Dental Health

Oral Health Plan & Consent

Patient's Name: **Birth Date:**

LAST **FIRST** **MI** **Preferred Name**

☐ Male ☐ Transgender Woman ☐ Non-Binary
☐ Female ☐ Transgender Man ☐ Other

Soc. Sec. #:

Preferred Language (if other than English)

E-mail Employer

(please check preferred) **Home Phone** **Mobile Phone** **Work Phone**

Address City/State/Zip County

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify

Race: **(check one or more)** ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Decline to Specify

How did you hear about us? ☐ Family/Friend ☐ Current Sonrisas DH Patient ☐ Internet ☐ Insurance Co. ☐ Dentist Referral ☐ Sonrisas DH Staff ☐ County Social Services ☐ Other _____

Purpose of Consent: By signing this form, I authorize Sonrisas Dental Health to provide comprehensive (initial) and periodic (recall) oral evaluations, x-rays and preventive care. If these services are non-covered or are denied by my insurance carrier, I will be held responsible for payment. Following each evaluation, I understand that I will be provided with a written treatment plan and treatment will not be started without further consent.

Right to Revoke: I have the right to revoke this Consent at any time by giving written notice of my revocations submitted to Sonrisas Dental Health. I understand that revocation of this Consent will not affect any action Sonrisas Dental Health too in reliance on this Consent before they received my revocation and that they may decline to treat me or to continue treating me if I revoke this Consent.

Appointment Policy: If for any reason you are unable to keep an appointment, please notify our office 24 hours in advance. Missing an appointment without such notification will be considered a failed appointment. Missing two dental appointments can result in dismissal from our clinic. Please be on time for your appointment. If you are not able to be on time, your appointment may be given to another patient who is waiting.

☐ **I have viewed or received a copy of the Dental Materials Fact Sheet**

Patient or Representative Signature* _____ **Date** _____

If the patient is a minor or does not make their own treatment decisions, the parent, legal guardian, or representative must sign above and complete the information below:

Relationship to Patient _____

Representative Name _____ **Address** _____

City/State/Zip _____ **Email** _____

_____ _____ _____

Home Phone **Mobile Phone** **Work Phone**

Please complete reverse page

San Mateo Center 430 N. El Camino Real, San Mateo, CA 94401-3710 * Phone: 650-727-3480 * Fax: 650-727-3519
Coastside Center 210 San Mateo Road, Suite 104, Half Moon Bay, CA 94019 * Phone 650-726-2144 * Fax : 650-726-2726

Patient's Name _____ **Birth Date:** _____/_____/_____
LAST **FIRST** **MI**

Financial Information

☐ **Private Pay, Financial Guarantor**
Please complete below if someone other than the patient/representative indicated on reverse page is responsible for payment.

Name _____ Home Phone _____

Address _____ Mobile Phone _____

City/State/Zip _____ Work Phone _____

Email _____ Relationship to Patient _____

Preferred contact method (check one) ○ Home ○ Mobile ○ Work ◉ Email

☐ **DentiCal** ID # _____

Dental Insurance Information **Please present your dental insurance card to our staff.**

Insurance is designed to reimburse the policyholder for loss and is a contract between the policyholder and the insurance company. As a courtesy to you, we will submit your insurance claims on your behalf and will do all we can to help you collect legitimate claims. In the event your company is slow to pay or disallows the claim payment, the amount owed is your responsibility.

Patient Relationship to Subscriber (circle one)

Subscriber Name _____ ☐ Self ☐ Spouse ☐ Child

Subscriber ID # _____ Subscriber Birthdate _____

Employer _____ Group Name _____ Group # _____

Insurance Company _____ Insurance Phone _____

Insurance Co. Billing Address _____
Street City State Zip

DO YOU HAVE DUAL INSURANCE COVERAGE? ☐ No ☐ Yes **If yes, please complete the following:**

Patient Relationship to Subscriber (circle one)

Subscriber Name _____ ☐ Self ☐ Spouse ☐ Child

Subscriber ID # _____ Subscriber Birthdate _____

Employer _____ Group Name _____ Group # _____

Insurance Company _____ Insurance Phone _____

Insurance Co. Billing Address _____
Street **City** **State** **Zip**

Please complete reverse page

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Sonrisas Dental Health

Health History

Patient's Name _____ **Birth Date:** _____/_____/_____
LAST **FIRST** **MI**

If you are filling out this form for another person, please fill out the following:

Your Name: _____

Your Relationship
To the Patient: _____

Dental History

1. Former Dentist/Practice _____ Address _____
2. When did you last visit a dentist? _____ X-rays taken? ___ If yes: ☐ Full Mouth Series ☐ Bitewings (molars only)
   What work was done at that time? _____
   Has any dental treatment been recommended to you that you have not completed? ☐ Yes ☐ No
   If yes, please describe: _____
3. Are you experiencing any dental problems or pain at this time? ☐ Yes ☐ No
   If yes, please describe: _____
4. Are your teeth sensitive? ☐ Yes ☐ No If yes, what causes the sensitivity? _____
5. Are you concerned with bad breath (malodor)? ☐ Yes ☐ No
6. Have you ever had an injury or trauma to your face or mouth? ☐ Yes ☐ No
7. Are you aware of any TMJ problems? ☐ Yes ☐ No Does your jaw joint **click, pop, grind**, **lock** or **ache**? ☐ **Yes** ☐ **No)**
8. Do you wear dentures or partials? ☐ Yes ☐ No ☐ Upper Full ☐ Upper Partial ☐ Lower Full ☐ Lower Partial
9. Do you have any concerns/problems with your dentures? ☐ Yes ☐ No
   If yes, describe: _____
10. Have you ever been treated for gum disease? ☐ Yes ☐ No If yes, what was done? _____
11. Is there any other information that would be valuable for your dentist to know?
    _____

Medical History

1. Physician/Medical Clinic _____ Phone _____
   Address _____ Date of last medical exam _____
2. Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason(s)?
   _____
3. Are you presently taking any medications/drugs? (including over the counter medication)
   If yes, please list them _____
4. Are you allergic or sensitive to: ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Local anesthetic ☐ Latex
   ☐ Amoxicillin ☐ ASA ☐ NSAIDs ☐ NONE ☐ OTHER _____
5. (Women) Are you pregnant? Due Date _____ Are you or will you be nursing? ☐ Yes ☐ No

Please complete reverse page

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Sonrisas Dental Health

Patient's Name _____ **Birth Date:** _____/_____/_____
LAST **FIRST** **MI**

6. Do you smoke? ☐ Yes ☐ No If yes, how much? _____ How often? _____ For how long? _____
7. Do you chew tobacco? ☐ Yes ☐ No If yes, how often? _____ For how long? For how long? _____
8. Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____ For how long? _____ yrs.
9. Do you have, or have you ever had:

☐ Yes ☐ No	Congestive Heart Failure	☐ Yes ☐ No	Arthritis
☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Osteoporosis
☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Tube Feeding
☐ Yes ☐ No	Heart Surgery	☐ Yes ☐ No	Cancer
☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Chemotherapy
☐ Yes ☐ No	Heart Valve Replacement	☐ Yes ☐ No	Radiation
☐ Yes ☐ No	Cardiomyopathy	☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Angina Pectoris	☐ Yes ☐ No	COPD
☐ Yes ☐ No	Atrial Fibrillation	☐ Yes ☐ No	Hearing Impaired
☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Glaucoma
☐ Yes ☐ No	Rheumatic Heart Disease	☐ Yes ☐ No	Psychiatric Care
☐ Yes ☐ No	Congenital Heart Defect	☐ Yes ☐ No	Joint Replacement – Date of surgery _____
☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Oral herpetic lesions (cold sores)
☐ Yes ☐ No	GERD	☐ Yes ☐ No	HIV Positive
☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No	AIDS
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Physical Therapy
☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Chemical Dependency
☐ Yes ☐ No	Diabetes – Insulin Dependent	☐ Yes ☐ No	Chronic Kidney Disease
☐ Yes ☐ No	Diabetes – Non-Insulin Dependent	☐ Yes ☐ No	Dialysis
☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Anxiety
☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No	Depression
☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Bipolar
☐ Yes ☐ No	Hyperthyroidism	☐ Yes ☐ No	Alzhiemer's Disease
☐ Yes ☐ No	Hypothyroidism	☐ Yes ☐ No	Dementia, with behavioral disturbance
☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	Dementia, without behavioral disturbance
☐ Yes ☐ No	Bleeding Disorders	☐ Yes ☐ No	Autism
☐ Yes ☐ No	Fainting Spells	☐ Yes ☐ No	ADHD
☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Down Syndrome
☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Intellectual Disability
☐ Yes ☐ No	Hepatitis Type: ☐ **A** ☐ **B** ☐ **C (check one)**		☐ Moderate ☐ Severe ☐ Profound **(check one)**

Other conditions _____

10. Have you had any other serious illness, hospitalization or accident? If yes, describe _____
11. Do you have any special needs? If yes, describe _____
12. Do you take/have you ever taken oral or IV bisphosphonates (medication to treat osteoporosis or cancer) ☐ Yes ☐ No
13. Are you dependent on a wheelchair? ☐ Yes ☐ No If yes, you must complete **Safe Patient Handling Needs**

Emergency Contact _____ **Relationship** _____ **Phone** _____

Patient Signature* _____ **Date** _____

Patient Representative* _____ **Date** _____

* If you are filling out this form for someone else, or you are an interpreter, please sign above.

Please complete reverse page

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Sonrisas Dental Health

Acknowledgement of the Notice of Privacy Practices
&
Authorization for Release, Use and Disclosure of Protected Health Information

☐ **I have been offered and/or received a copy of Sonrisas Dental Health Inc.'s Notice of Privacy Practices; and I understand I can request a copy of it at any time. (Please check the box if you agree.)**

I authorize the release of my records for the purpose of continuity of care, including records from previous dentists. I consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care coordination, and for other reasons, following specific conditions of the law.

This consent will end one year from the date this form is signed, unless I indicate an expiration date or a specific event here:

☐ As long as I am a patient of Sonrisas Dental Health, Inc.
or
☐ Expiration Date _____/_____/_____, or a specific event ______________________

Patient's Name (Please Print) ____

Patient's Signature ____________________________ Date ____________________

If the patient is a minor or does not make their own treatment decisions, the parent, guardian, or representative must complete the following:

Patient Representative's Name (Please Print) ___________________________________

Patient Representative's Signature ____

Relationship to the Patient ___________________________ Date ______________

For Center Use Only: We attempted to obtain written acknowledgement of receipt of our NPP and consent for the release, use and disclosure of the individual's PHI as described above, but it could not be obtained because:

☐ The individual refused
☐ Communications barriers prohibited obtaining the acknowledgement and consent
☐ An emergency situation prevented us from obtaining acknowledgement and consent
☐ Other (please specify) _______________________________ SDH Staff Initials _________

rev. Jan 2019

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Sonrisas Dental Health

Privacy Release

According to our records, you are listed as being **self-responsible**. In compliance with our **Notice of Privacy Practices**, we must limit disclosure of protected health or financial information to you, or to the listed financial contact.

If you would like to give us written authorization to disclose protected health or financial information to any other person with regard to your dental care, list their name(s) below. Please sign and date in the area provided.

Please call our office if you have any questions.

Sonrisas Dental Health Inc. has my permission to disclose protected health or financial information to the person(s) listed below:

Name (Please Print)	**Relationship to Patient**	**Phone Number**
Name (Please Print)	**Relationship to Patient**	**Phone Number**

Patient Name (Please Print)	**Patient's Signature**	**Date**

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
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
www.dbc.ca.gov

Published by
California Department of Consumer Affairs
5/04

The Facts About Fillings

The Facts About Fillings

DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
www.dbc.ca.gov

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

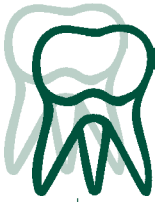
Composite fillings are a mixture of powdered glass and plastic resin, sometimes referred to as white, plastic, or tooth-colored fillings. It is used for fillings, inlays, veneers, partial and complete crowns, or to repair portions of broken teeth.

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



Sonrisas Dental Health

NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: November 1, 2017

Offices Address: 430 North El Camino Real, San Mateo, CA 94401-3710 (Attention Office Manager)
Phone: 650-727-3480, Toll Free: 844-403-7887; Fax**:** 650-727-3519**; Web site:** www.sonrisasdental.org
Privacy Officer: Bonnie Jue, DDS; Phone**:** 650-727-3480; Email**:** bonnie.jue@sonrisasdentalhealth.org

This Notice of privacy practices describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect November 1, 2017 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

For more information about our privacy practices or additional copies of this Notice, please contact us using the information above.

PATIENT RIGHTS

Access to Your Health Information: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for our fee information.

Disclosure Accounting: You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification: In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations you may be notified by our business associates.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances and explain why in writing within 60 days.

Questions and Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us using the contact information above. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights at 200 Independence Avenue, S.W., Washington, DC 20201; or call 1 -877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: November 1, 2017

USES AND DISCLOSURES OF HEALTH INFORMATION:

1. For Treatment, Payment, or Healthcare Operations:

We use and disclose health information about you for treatment, payment, and healthcare operations.

For Treatment: We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare provider providing treatment that we do not provide. We may also share your health information with a pharmacist to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

For Payment: We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket in full for services rendered.

For Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, business planning, management and administrative services, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs and education, accreditation, certification, licensing or credentialing activities. We may use and disclose your health information to an outside company that performs services for us such as legal, computer or auditing services, and medical and dental laboratories services. These outside companies are called “business associates,” and are required by law to keep your Health Information confidential.

2. Your Authorization:

In addition to our using your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

3. Additional Uses and Disclosures of Health Information

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

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Persons Involved in Your Care or Payment of Your Care: We may use or disclose your health information to someone who helps pay for your care. We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: November 1, 2017

3. Additional Uses and Disclosures of Health Information (continued from page 2)

Unsecured Email: We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize unsecured email communications, you have the right to revoke the authorization anytime.

Required by Law: We may use or disclose your health information when federal or state law requires us to do so, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Change of Ownership: If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Public Health: We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting on your condition, status and location to disaster relief entities; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

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. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or others health or safety.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Medical Examiner, Coroner or Funeral Director: We can share health information about you with a coroner or medical examiner, or funeral director when an individual dies.

Workers' Compensation & Law Enforcement, Lawsuits and Legal Actions: We may use or disclose your health information for Workers' Compensation or similar programs as authorized or required by law. We may also use or share health information about you for law enforcement purposes or with a law enforcement official and with health oversight agencies for activities authorized by law. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Research: We can use or share your information for health research. We may disclose your health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Appointment Reminders: We may contact you about an upcoming appointment by voicemail, email, text, postcard, or letter.

Sign In Sheet and Announcement: Upon arriving at our office, we may use and disclose medical information about you by asking you to sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Complying with Special Laws: There are special laws that protect some types of health information such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice.

Privacy Officer Contact Information: Please refer to the contact information box on the top of page 1.