

Grace Dental
1210 S. Euclid, La Habra, Ca 90631
(714) 871 - 4962

PATIENT INFORMATION:

Last Name First Name M

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed / E-mail address: _____

For Dependent Children: Student: ___ No ___ Yes, Name of School? _____ City _____

Nickname: _____ Birthdate _____ SS# _____ - _____ - _____ Sex ___ M ___ F

Address: _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell # _____

Employer _____ Occupation _____ State _____ Zip _____

Employer Address _____ City _____ State _____ Zip _____

Why are you here today? _____ Date of Last dental visit _____

Spouse's Name _____ Occupation _____

Spouse Employer: _____
Company Street City CA Zip

ACCOUNT INFORMATION/ POLICY HOLDER:

CHECK IF POLICY HOLDER INFORMATION IS SAME AS ABOVE

2nd Insurance ___ No ___ Yes Name of Insurance _____

Last Name First Name M

Mailing Address: _____
Street City CA Zip

Home Phone _____ Work Phone _____ E-mail _____

Social Security No. _____ Birthdate _____ Driver's License # _____

REFERRAL INFORMATION:

Referred by: ___ Pass by ___ Insurance Lists ___ Flyers ___ Friend ___ Others ___ Name _____

In case of emergency, please call: _____ Tel. # _____

I hereby authorize the release of any information including the diagnosis and the records of any treatment, or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits under which I am entitled. Authorization is hereby granted to *Eliza Berris DDS*.

PLEASE INITIAL EACH APPLICATION BOX

- I Acknowledge of receipts of a copy of this office's NOTICE OF PRIVACY PRACTICES
- Knowledge of receipts of a copy of the 2004 DENTAL MATERIAL FACTS SHEET as required by law
- I have been informed and I am aware that I will be charged a \$50.00 fee if I failed to cancel or /reschedule my appointment 24 hours or more in advance.

Signature of Patient Date

Signature of responsible Party Date

DENTAL OFFICE POLICY

Patients with Dental Insurance: As a courtesy to you, our office will gladly submit to your insurance. We are able to bill to all traditional, indemnity insurance plans. We do not accept DMO or DPO plans (Dental Maintenance or Dental Provider Organizations). Under these plans, there is no coverage when treatment is rendered by a non-participating dentist. Please check your type of plan carefully.

Patients with Delta Dental Insurance: "Your Office Name Here" is a participating "PREMIERE" provider (not PPO). However, for all PPO plans, even though " **Knoll Family Dentistry** " is out-of- network, we are still able to bill your insurance and benefits are payable. For more specific information about out-of- network benefit amounts, please call your insurance company.

Authorization to Release Info and Assignment of Benefits: I certify that I, _____, (or my dependent) have (has) dental insurance coverage and assign directly to "Your Office" all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor and/or her staff to release all necessary personal information to my insurance company in order to secure the payment of benefits.

Payments: We accept cash, check, VISA, MasterCard, and Discover. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule, and not our office's actual fees, which may result in a balance due higher than expected. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. Our office policy does not allow partial payments. If a credit balance should result after insurance processes your claim, a refund will be promptly issued to you.

Unpaid Insurance Claims: All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

Past-Due Accounts: If payment is not received by the due date printed on the statement, then your account is considered "past due". We reserve the right to charge a \$5.00 per month billing charge on all past due accounts. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees that this office incurs while attempting to collect on the unpaid balance. These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

Patients without Dental Insurance: Payment in full is expected at the time services are rendered. We accept cash, check, VISA, MasterCard, and Discover. If, however, payment is made with cash or check, a 5% discount is provided. We are unable to provide this discount if payment is made with a credit card.

"**Knoll Family Dentistry**" reserves the right to update and make changes the above-stated office policies at any time without prior notification.

By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

Patient Name (print): _____ Date: _____

Responsible Party Signature: _____ Relationship to patient: _____

The Dental Board of California

Dental Materials Fact Sheet

Supplied by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble), and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled, "Comparisons of Restorative Dental Materials." A "glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Both the public and the dental profession are concerned about the safety of dental treatment and any potential health risks that might be associated with the materials used to restore the teeth. All materials commonly used (and listed in this fact

sheet) have been shown- through laboratory and clinical research as well as through extensive clinical use - to be safe and effective for the general population. The presence of these materials in the teeth does not cause adverse health problems for the majority of the population. There exist a diversity of various scientific opinions regarding the safety of mercury dental amalgams. The research literature in peer-reviewed scientific journals suggests that otherwise healthy women, children, and diabetics are not at increased risk for exposure to mercury from dental amalgams. Although there are various opinions with regard to mercury risk in pregnancy, diabetes, and children, these opinions are not scientifically conclusive and therefore the dentist the dentist may want to discuss these opinions are not scientifically conclusive and therefore the dentist may want to discuss these opinions with their patients. There is no research evidence that suggests pregnant women, diabetics and children are at increased health risk from dental amalgam fillings in their mouth. A recent study reported in the JADA factors in a reduced tolerance (1/50th of the WHO safe limit) for exposure in calculating the amount of mercury that might be taken in from dental fillings. This level falls below the established safe limits for exposure to a low concentration of mercury or any other released component from a dental restorative material. Thus, while these sub-populations may be perceived to be at increased health risk from exposure to dental restorative materials, the scientific evidence does not support that claim. However, either are individuals who may be susceptible to sensitivity, allergic or adverse reactions to selected materials. As with all dental materials, the risks and benefits should be discussed with the patient, especially with those in susceptible populations.

There are differences between dental materials and the individual elements or components that compose these materials. For example, dental amalgam filling material is composed mainly of mercury (43-54%) and varying percentages of silver, tin, and copper (46-57%). It should be noted that elemental mercury is listed on the Proposition 65 list of known toxins and carcinogens. Like all materials in our environment, each of these elements by themselves is toxic at some level of concentration if they are taken into the body. When they are mixed together, they react chemically to form a crystalline metal alloy. Small amounts of free mercury may be released from amalgam fillings over time and can be detected in bodily fluids and expired air. The important question is whether any free mercury is present in sufficient levels to pose a health risk. Toxicity of any substance is related to dose, and doses of mercury or any other element that may be released from

Types of Restorative Dental Materials				
Comparative Factors	Amalgam	Composite Resin (direct and indirect Restorations)	Glassionomer cement	Resin ionomer cement
General Description	Self-hardening mixture in varying percentages of a liquid mercury and silver-tin alloy powder	Mixture of powdered glass and plastic resin, self-hardening or hardened by exposure to blue light	Self-hardening mixture of glass and organic acid	Mixture of glass resin polymer and organic acid self-hardening by exposure
Principle Users	Fillings sometimes for replacing portions of broken teeth	Fillings, inlays veneers, partial and complete crowns, sometimes for replacing portions of broken teeth	Small fillings cementing metal & porcelain metal crown, inlays	Small fillings cementing metal, porcelain metal crowns, inlays
Resistance to Further Decay	High, self-sealing characteristic helps resist recurrent decay but recurrent decay around amalgam is difficult to find in early stage	Moderate, recurrent decay is easily detected in early stages	Low/moderate some resistance to decay may be imparted through fluoride release	Low/moderate resistance to decay may be imparted through fluoride release
Estimated Durability (Permanent teeth)	Durable	Strong, durable	Non-stress bearing crown cement	Non-stress bearing crown cement
Relative Amount of Tooth Preserved	Fair, requires removal of healthy tooth to be mechanically retained, no adhesive bond of amalgam to the tooth	Excellent, bonds adhesively to healthy enamel and dentin	Excellent, bonds adhesively to healthy enamel and dentin	Excellent, bond adhesively to the enamel and dentin
Resistance to Surface Wear	Low similar to dental enamel, brittle metal	May wear slightly faster than dental enamel	Poor in stress bearing applications. Fail in non-stress bearing applications	Poor in stress bearing applications. Good in non-stress bearing application
Resistance to Fracture	Amalgam may fracture under stress, both around filling may fracture before the amalgam does	Good resistance to fracture	Brittle, low resistance to fracture but not recommended for stress-bearing restorations	Tougher than glass-ionomer. Recommended to stress bearing restoration
Resistance to Leakage	Good, self-sealing by surface corrosion, margins may chip over times	Good if bonded to enamel, may show leakage over time when bonded to dentin, does not compromise	Moderate, tends to crack over time	Good, bonded to resin, and dentinal postinsert expansion may be seal the margins
Resistance to Occlusal Stress	High, but lack of adhesion may weaken the remaining tooth	Good to excellent depending upon product used	Poor, not recommended for stress-bearing restorations	Moderate, not recommended to restore biting surface of adults, maybe used for short term primary teeth restoration
Toxicity	Generally safe, occasional allergic reactions to metal components. However, amalgams contain mercury. Mercury in its elemental form is toxic and as such is listed on prop 65	Concerns about trace chemical release are not supported by research studies. Safe, no known toxicity documented. Contains some compounds listed on prop 65	No known incompatibilities safe, no known toxicity documented	No known incompatibilities safe, no known toxicity documented
Allergic or Adverse Reactions	Rare, recommend that dentist evaluate patient to rule out metal allergies	No documentation for allergic reactions was found	No documentation for allergic reactions was found, progressive roughening of the surface may predispose to plaque accumulation and periodontal disease	No known documented allergic reactions. Surface may roughen over time, predispose to plaque accumulation and periodontal disease
Susceptibility To Post-Operative Sensitivity	Minimal, high thermal conductivity may promote temporary sensitivity to hot & cold, contact with other metals may cause occasional & transient galvanic response	Moderate, material is sensitive to dentist's technique, material shrinks slightly when hardened, and a poor seal may lead to bacterial leakage, recurrent decay and tooth hypersensitivity	Low, material seals well and does not irritate pulp	Low, material seals well and does not irritate pulp
Esthetics (Appearance)	Very poor. Not tooth colored, initially silver-gray gets darker becoming black as it corrodes. May stain teeth dark brown or black over time	Excellent, often indistinguishable from natural tooth	Good, tooth colored, varies in translucency	Very good, more translucency than glass ionomer
Frequency of Repair or Replacement	Low, replacement is usually due to fracture of the filling or the surrounding tooth	Low to moderate, durable material hardens rapidly. Some composite materials show more rapid than amalgam. Replacement	Moderate, slowly dissolves in mouth, easily dislodged	Moderate, may hold better than ionomer but not as well as composite
Relative Costs to Patient	Low, relatively inexpensive, actual cost of fillings depends upon their size.	Moderate, higher than amalgam fillings, actual cost of fillings depends upon their size, veneers & crowns cost more	Moderate, similar to composite resin (not used for veneer and crowns)	Moderate, similar to composite resin (not used for veneer and crowns)
Number of Visits	Single visit (polishing)	Single visit for fillings, more for veneers & crowns	Single visit	Single visit

dental amalgam fillings falls far below the established safe levels as stated in the 1999 US Health and Human Service Toxicological Profile for Mercury Update.

All dental restorative materials (as well as all materials that we come in contact with in our daily life) have the potential to elicit allergic reactions in hypersensitive individuals. These must be assessed on a case-by-case basis, and susceptible individuals should avoid contact with allergenic materials. Documented reports of allergic reactions to dental amalgam exist (usually manifested by transient skin rashes in individuals who have come into contact with the material), but they are atypical. Documented reports of toxicity to dental amalgam exist, but they are rare. There have been anecdotal reports of toxicity to dental amalgam and as with all dental material risks and benefits of dental amalgam should be discussed with the patient, especially with those in susceptible populations.

Composite resins are the preferred alternative to amalgam in many cases. They have a long history of biocompatibility and safety. Composite resins are composed of a variety of complex inorganic and organic compounds, any of which might provoke allergic response in susceptible individuals. Reports of such sensitivity are atypical. However, there are individuals who may be susceptible to sensitivity, allergic or adverse reactions to composite resin restorations. The risks and benefits of all dental materials should be discussed with the patient, especially with those in susceptible populations.

Other dental materials that have elicited significant concern among dentists are nickel-chromium-beryllium alloys used predominantly for crowns and bridges. Approximately 10% of the female populations are alleged to be allergic to nickel. The incidence of allergic response to dental restorations made from nickel alloys is surprisingly rare. However, when a patient has a positive history of confirmed nickel allergy, or when such hypersensitivity to dental restorations is suspected. Alternative metal alloys may be used. Discussion with the patient of the risks and benefits of these materials is indicated.

Glossary of Terms

General Description

Principle Uses- the types of dental restorations that are made from this material

Resistance to further decay- the general ability of the material to prevent decay around it

Longevity/durability- the probable average length of time before the material will have to be replaced (this will depend upon many factors unrelated to the material such as biting habits of the patient. The diet, the strength of their bite, oral hygiene, etc)

Conservation of Tooth Structure- a general measure of how much tooth needs to be removed in order to place and retain the material

Surface wear/fracture resistance- a general measure of how well the material holds up over time under the forces of biting, grinding, denching, etc.

Marginal integrity (leakage)- an indication of the ability of the material to seal the interface between the restoration and the tooth, thereby helping to prevent sensitivity and new decay.

Resistance to occlusal stress- the ability of the material to survive heavy biting forces over time

Biocompatibility- the effect, if any, of the material on the general overall health of the patient

Allergic or adverse reactions- possible systemic or localized reactions of the skin, gums, and other tissues to the materials

Toxicity- an indication of the ability of the material to interfere with normal physiologic processes beyond the mouth

Susceptibility to sensitivity- an indication of the probability that the restored teeth may be sensitive stimuli (heat, cold, sweet, pressure) after the material is placed in them

Esthetics- indication of the degree to which the material resembles natural teeth

Frequency of repair or replacement- an indication of the expected longevity of the restoration made from this material

Relative cost- a qualitative indication of what one would pay for a restoration made from this material compared to all the rest

Number of visits required- how many times a patient would usually have to go to the dentist's office in order to get a restoration made from this material

Dental amalgam- filling material which is composed mainly of mercury (43-54%) and varying percentages of silver, in, and copper(48-57%)

TYPES OF INDIRECT RESTORATIVE DENTAL MATERIALS				
Comparative Factors	Porcelain (ceramic)	Porcelain (fused to metal)	Gold alloys (noble)	Nickel or Cobalt-chrome (base-metal) alloys
General Description	Glass-like material formed into fillings and crowns using models of the prepared teeth	Glass-like material that is enameled onto metal shells. Used for crowns and fixed bridge	Mixtures of gold, copper and other metals used mainly for crowns and fixed bridges	Mixtures of nickel, chromium
Principle Users	Inlays, veneers, crowns and fixed bridges	Crowns and fixed bridges	Cast crowns & fixed bridges; some partial denture frameworks	Crowns and fixed bridges; most partial denture frameworks
Resistance to Further Decay	Good, if the restoration fits well	Good, if the restoration fits well	Good, if the restoration fits well	Good, if the restoration fits well
Estimated Durability (permanent Teeth)	Moderate; brittle material that may fracture high biting forces, not recommended for posterior (molar) teeth	Very good, less susceptible to fracture due to the metal substructure	Excellent; does not fracture under stress; does not corrode in the mouth	Excellent; does not fracture under stress; does not corrode in the mouth
Relative Amount of Teeth Preserved	Good; moderate removal of natural tooth is necessary for veneers; more for crowns since strength is related to its bulk	Moderate-high; More tooth must be removed to permit the metal to accompany the porcelain	Good, a strong material that requires removal of a thin outside layer of the tooth	Good, a strong material that requires removal of a thin outside layer of the tooth
Resistance to Surface Wear	Resistant to surface wear, but abrasive to opposing teeth	Resistant to surface wear, permits either metal or porcelain on the biting surface of crowns & bridge	Similar hardness to natural enamel; does not abrade opposing teeth	Harder than natural enamel but minimally abrasive to opposing natural teeth; not fracture in bulk
Resistance to Fracture	Poor resistance to fracture	Porcelain may fracture	Does not fracture in bulk	Does not fracture in bulk
Resistance to Leakage	Very good can be truncated for very accurate fit of the margins	Good; very good depending upon design of the margins of the crowns	Very good-excellent. Can be formed with great precision, can be tightly adapted to the tooth	Good-very good; stiffer than gold; less adaptable, but can be formed with great precision
Resistance to Occlusal Stress	Moderate; brittle material susceptible to fracture under biting forces	Very good. Metal substructure gives high resistance to fracture	excellent	Excellent
Toxicity	Excellent. No known adverse effects	Very good to excellent. Occasionally rare allergy to metal alloys used	Excellent; rare allergy to some alloys	Good; nickel allergies are common among women, although rarely manifested in dental restorations
Allergic or Adverse Reactions	none	Rare. Occasional allergy to metal substructures	Rare; occasional allergic reactions seen in susceptible individual	Occasional; infrequent reactions to nickel
Susceptibility To Post-Operative Sensitivity	Not material dependent; does not conduct heat and cold well	Not material dependent; does not conduct heat and cold well	Conducts heat and cold; may irritate sensitive teeth	Conducts heat and cold; may irritate sensitive teeth
Esthetics (Appearance)	excellent	Good to excellent	Poor-yellow metal	Poor-dark silver metal
Frequency of Repair or Replacement	Varies; depends upon biting forces; fractures of molar teeth are more likely than anterior teeth; porcelain fracture may often be repaired with composite resin	Infrequent; porcelain fracture can often be repaired with composite resin.	Infrequent; replacement is usually due to recurrent decay around margins	Infrequent; replacement is usually due to recurrent decay around margins
Relative Costs to Patient	High; requires at least two office visits and laboratory services	High; requires at least two office visits and laboratory services	High; requires at least two office visits and laboratory services	High; requires at least two office visits and laboratory services
Number of Visits Required	Two-minimum; matching esthetics of tooth may require more visits	Two-minimum; matching esthetics of tooth may require more visits	Two-minimum	Two-minimum

I acknowledge receiving dental material sheet.

Signature _____

Date _____

PATIENT HEALTH HISTORY

Name: _____

Date of last Medical Exam: _____

How would you describe your health? ___ Excellent ___ Very Good ___ Good ___ Fair ___ Others: Please describe: _____

Do you have a Medical Physician? ___ No ___ Yes: Name of Physician: _____ Tel. # _____

1. Are you now or have been under the care of a physician within the past five years? ___ No ___ Yes, If so why? _____
2. Have you had any major surgery or hospitalization? ___ No ___ Yes, Describe: _____ When: _____
3. Are you now or have you recently been taking any medication? If so, For what? _____
4. Have you taken Phen-fen / Redux before? ___ No ___ Yes When? _____ Have you seen your physician after that? _____
5. Are you allergic to or have any reactions to any of the following:

	Y	N		Y	N		Y	N
Local Anesthetics (e.g. Novocain)			Aspirin			Iodine		
Penicillin or any other antibiotics			Codeine			Latex rubber		
Sulfa Drugs			Barbiturates			Others (Please list)		
Any metals (e.g. Nickel, mercury)			Sedatives					

6. WOMEN ONLY: Y N

a.) Are you pregnant or think may be pregnant?		
b.) Are you nursing?		
c.) Are you practicing birth control medication?		

7. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

	Y	N		Y	N		Y	N		Y	N
Heart Attack			Joint Replacement Implant			Epilepsy or Seizures			Gonorrhea		
Heart Failure			Kidney Trouble			Glaucoma			Cold Sores		
Heart Surgery			Ulcers			Pain in Jaw Joints			Genital Herpes		
Heart Disease			Arthritis			Aids or HIV Infection			Fainting/dizzy spells		
Angina Pectoris			Emphysema			Liver Disease			Nervousness		
Heart Murmur			Tuberculosis			Hepatitis A (infectious)			Psychiatric Treatment		
High Blood Pressure			Asthma			Hepatitis B (serum)			Sickle cell Disease		
Rheumatic Fever			Hay Fever/Allergies			Hepatitis C (Bleeding gums		
Congenital Heart Defect			Sinus Trouble			Yellow Jaundice			Tooth pain		
Scarlet Fever			Diabetes			Blood Transfusion			Bad breath		
Artificial Heart Valve			Thyroid Disease			Drug Addiction			Chronic Headaches		
Mitral Valve Prolapse			Radiation Therapy			Hemophilia			Chronic Neck aches		
Heart Pacemaker			Chemotherapy			Syphilis					
Stroke			Cancer			Leukemia					
Others not listed: _____											

PATIENT DENTAL HISTORY

	Y	N		Y	N
Do your gums bleed while brushing or flossing?			8. Do you have frequent headaches?		
Are your teeth sensitive to hot or cold liquids/foods?			9. Do you clench or grind your teeth?		
Are your teeth sensitive to sweet or sour liquids /foods?			10. Do you bite your lips or cheeks frequently?		
Do you feel pain to any of your teeth?			11. Have you ever had any difficulty with extractions in the past		
Do you have any sores or lumps in or near your mouth?			12. Have you had any orthodontic treatment		
Have you had any head, neck or jaw injuries?			13. Have you had any prolonged bleeding following extractions		
Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures, partials, If yes, date of placement:		
A. Clicking					
B. Pain (joint, ear, side of face)			15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
c. Difficulty in opening or closing			16. Do you smoke?		
d. Difficulty in chewing			17. Do you like your smile?		

AUTHORIZATION AND RELEASE: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/ or health practitioners.

Signature of Patient/Parent or Guardian: _____ Date: _____

Doctor's Signature: _____ Date: _____

GRACE DENTAL

1210 S. Euclid La Habra, CA 90631
(714) 871-4962

HIPAA 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 REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES and DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment, for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training or medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical /dental school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use to disclose your PHI, as necessary, to contract you to remind you or your appointment or send you a post card (recall card) to inform your next exam and cleaning.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, Health oversight, abuse or neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement; Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security. Worker's Compensation: Inmates: Required uses and disclosure. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES: Will Be made only with your consent, authorization or opportunity to object unless required by law.

YOU MAY REVOKE THIS AUTHORIZATION, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

YOUR RIGHTS: Following is a statement of your rights with respect to your protected health information.

GRACE DENTAL

1210 S. Euclid La Habra, CA 90631

(714) 871-4962

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

YOU HAVE THE RIGHT TO RESPECT A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this NOTICE OF PRIVACY PRACTICES. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even if you have agreed to accept this notice alternatively i.e. electronically,

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complete with us by notifying our privacy contact of your complaint. We will not retaliate against you for filling a complaint.

This notice was published and becomes effective on or before **January 14, 2022.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this NOTICE OF OUR PRIVACY PRACTICES.

Print Name: _____ Signature: _____ Date: _____

"GRACE DENTAL"

FINANCIAL RESPONSIBILITY FORM

Patient's Name: _____ Date of Birth: __/__/____

Address: _____

Telephone # _____ - _____ Work # _____ - _____ Social Security No: _____ - _____ - _____

Employer: _____ Dental Insurance Carrier: _____

ID # _____ Group # _____

If Patient is under the age of 18, name of individual who is financially responsible for Patient: _____

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct insurance information is provided at the time of the patient's appointment. If this information changes, it is the patient's responsibility to update "Your Office Name Here" at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to "Your Office Name Here". We do accept payments from the dental insurance companies; however, we are not contracted with them. It is a contract between you, your employer and the insurance company.

If requested, we will provide you with a verbal ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and/or account holder.

Payment for co-pays and/or deductibles is due at the time services are provided.

Any balance older than 90 days will be subject to interest charges of 1.5% per month, from the date of service, until the account is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney, additional collection fees will be applied to any unpaid balance. **Any attorney or collections fees incurred due to delinquency in payment or collection efforts will also be charged to you, including court costs and fees.** Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a \$15 NSF check fee and may also subject you to court costs and attorney fees.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all the terms and conditions herein.

Signature Date: __/__/____

Signature

GRACE DENTAL

1210 S. Euclid La Habra, CA 90631
(714) 871-4962

Arbitration Agreement

I agree to address any grievances I may have directly with Dr Eliza Berris & Associates immediately. If we cannot settle the matter between us then a jointly agreed upon outside consultation will be sought. If not, an arbitration process will be initiated which will be considered as a complete resolution and legally binding decision under California law, which states us, follows:

“NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL/DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRAION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT.”

Article 1: “It is understood that any dispute as to dental malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.” Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above identified grievance procedures.

This agreement constitutes the entirety of our professional contract. Both parties must sign any changes. I have the right to keep a copy of this contract.

Patient Signature: _____

Legal Parent or Guardian Signature: _____

Date: _____

This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. I have assessed the client’s mental capacity and found the client capable of giving an informed consent at this time.

Dentist Signature: _____

Date: _____

GRACE DENTAL

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Patient Email and Text Message Informed Consent

This form provides information on how Grace Dental will communicate by email address and text message (also known as SMS). It will also be used to document your consent and authorization for communication with you by email and text message.

How we will use email and text messaging:

We use these methods of communication only for non-sensitive and non-urgent matters. Communications to or from you may be documented onto your medical records.

We will not disclose your email or text message with others required by state or federal law. Please refer to our Notice of Privacy Practices for information as to permit uses of your health information and your rights regarding privacy matters.

Authorization to Send Emails/Text Messages:

_____ I accept and Do want to receive email or text messages.

_____ I decline and DO NOT want to receive email or text messages at this time.

Email address: _____

Cell phone #: _____

Patient name: (Print) _____

Patient/Guardian of Patient: (Signature) _____

GRACE DENTAL
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(714) 871-4962

Appointment Cancellation Policy

If you must cancel an appointment, please call at least 24-hours in advance. 24-hour notice is defined as one business day. Message left over the weekend are not considered sufficient notice.

If you miss or cancel two appointment without 24-hour notice, you may be unable to schedule any further appointments in advance.

Failure to cancel without 24-hour notice will result in a \$50 fee. You are responsible for this fee; It will not be billed to insurance. No further appointments will be scheduled until this cancellation fee has been reconciled.

Patient Signature: _____ Date: _____

CO-Pay

Insurance patients are responsible to know their own individual insurance coverage. As a courtesy to our patients we will call the insurance to verify benefits and co-payments, but cannot guarantee the information we are provided is correct. CO-PAYMENTS ARE DUE AT THE TIME OF EACH VISIT.

Patient Initial: _____