

Plaremont Smile Design

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

**** You May Refuse to Sign This Acknowledgement****

In accordance with federal law, I _____, have received a copy of this office's Notice of Privacy Practices.

Do you give us permission to confirm appointments by phone, message, and by mail? Yes No

Do you give us permission to discuss your treatment, insurance coverage, and treatment plan with a family member?
Yes No

If so, please list the names of those you authorize our office to discuss this information with:

Print Patient's Name

Patient/Responsible Party's Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual Refused to Sign Communication Barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify): _____

Claremont Smile Design

175 N. Indian Hill Blvd., Suite B-207
Claremont, California 91711
(909)624-1111 - Fax (909)624-3212
claremontsmiledesign.com

NOTICE OF PRIVACY PRACTICES

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

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11.01.00, 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 the 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.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of 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 anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was 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.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We must 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 will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable 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 the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personal 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: 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 for to request access by using the contact information listed at the end of this Notice. 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 to the address at the end of this Notice. If you request copies we will charge you \$0.50 for each page, \$25.00 per hour for our staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative 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 using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business association disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 5 years, but not before April 14, 2003. 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 request.

Restriction: 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 an emergency)

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 how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

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 complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file the complaint with us or with the U.S. Department of Health and Human Services.

Contact Name: Joseph S. – Office Manager
Telephone: (909)624-1111 Fax: (909)624-3212
E-Mail: claremontsmiledesign@verizon.net
Address: 175 N. Indian Hill Blvd., Suite B-207 Claremont, CA 91711



Patient Dental Treatment Consent Form

Examination, X-Rays, & Diagnosis

- I understand that dental x-rays (radiographs) are a necessary part of the diagnosis process and consent to having any dental x-rays (radiographs) necessary. I understand that the examination and diagnosis process involves x-rays (radiographs), oral cancer screening, and perio char probing and I consent to this process. I understand that should treatment be diagnosed for me that I will be given the opportunity to ask any questions. Also, any fees associated with any treatment will be discussed with me at that time.

Initials _____

Oral Hygiene and Periodontics

- I understand that the long term success of treatment and status of my oral condition depends strongly on my efforts to maintain proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits as recommended by Dr. Jaquez.

Initials _____

- I understand that I have a serious condition, causing gum and bon inflammation and/or loss, that if it can lead to the loss of my teeth and many other complications. The various treatment plan options have been explained to me, including gum therapy and/or surgery, and replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extractions.

Initials _____

Changes in Treatment Plan

- I understand that during treatment it may be necessary to change and or add treatment procedures due to conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy, following routine restorative procedures, I give my permission to Dr. Jaquez to make any/all changes to my treatment plan as necessary.

Initials _____

Drugs, Medications, and Anesthesia

- I understand that antibiotics, analgesics, and other medications may cause diverse reactions, some of which are, but are not limited to; redness, swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, and cardiac arrest. I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol and/or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous devise while taking medication and/or drugs until fully recovered from their effects. I understand that occasionally upon injection of local anesthetic, I may have prolonged, persistent anesthesia, numbness and/or irritation to the area of injection.

Initials _____

- I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloral Hydrate, "Zauax", or any other sedative possible risks includes, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation and that someone needs to watch me closely for a period of 6 to 8 hours thereafter.

Initials _____

Fillings – Restorations

- I have been advised of the need for fillings, Composite Resin (Tooth Colored), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to the wear of the material. In cases where very little tooth structure remains or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate fee.

Initials _____

Endodontic Treatment (Root Canal Therapy)

- I realize that there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (i.e. extractions and opioectomy).

Initials _____

- Alternatives to the removal of teeth if any have been explained to me including, root canal therapy, crowns, and or periodontal surgery, and I authorize Dr. Jaquez to remove the following teeth _____ and any others necessary due to the possibility of treatment plan changes as outlined above. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, and loss of feeling in my teeth, lips, tongue, and surrounding tissue which may last for an indefinite period of time (days or months). I understand that should I need further treatment by a specialist or even hospitalization, if complications should arise, the cost of such is my responsibility.

Initials _____

Crowns (Caps) and Bridges

- I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand that at times during the preparation of a tooth for a crown or bridge, pulp exposure may occur, necessitating root canal therapy. I understand that natural teeth, crowns, and bridges need to be kept clean, by maintaining proper regular and oral hygiene and periodic cleanings and exams. Otherwise, decay (cavity) may develop underneath and/or around the margins of the restoration, leading to the need for further dental treatment.

Initials _____

Dentures, Complete or Partial

- I realize that full or partial dentures are artificial, constructed of acrylic, metal and/or porcelain. The problems or wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. I understand that any adjustments done within 3 months of the delivery of the appliance are included in the original treatment fee, and that any adjustments beyond that will be at \$75.00 per visit, per appliance. In addition, I understand that most dentures and partials require relining approximately three to six months after initial placement. The cost for this procedure is not included in the initial treatment fee.

Initials _____

General Consent

- I understand that any insurance benefits quoted are not a guarantee of benefits but, rather an estimate based on the information provided to our office by your insurance carrier. I understand that I will be financially responsible for any amount(s) not covered by my insurance carrier. I understand that it is the patient's responsibility to know and understand their individual insurance benefits and that this office has verified my insurance benefits as a courtesy to me.

Initials _____

- I understand that should I fail to make payment on my account that a \$15.00 per month late charge will be applied. In addition I understand that I will be responsible for a \$25.00 returned check fee for any and all returned checks. Also, should my account be referred to collections, I understand that I am responsible for a \$50.00 Administrative Collection Fee in addition to any outstanding balance.

Initials _____

- I understand that this facility provides dental care services without discrimination based on race, religion, color, nationality, sex, sexual orientation, physical or mental disability, age and/or, and protect the privacy of each of its individual patients.

Initials _____

- I certify that I have had the opportunity to read and fully understand the terms and conditions outlined within this document, and consent to cooperation and/or explanation referred to or made. I have been encouraged to ask questions, and have had them answered to my satisfaction.

Initials _____

Print Patient's Name

Date

Responsible Party's Signature

Relationship to Patient

FOR OFFICE USE ONLY

Doctor's Signature

Date

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____, acknowledge receipt of a copy of the Dental

Materials Fact Sheet from Claremont Smile Design as mandated

by the Dental Board of California as of October 2001.

Patient's Name

Patient's / Responsible Party's Signature

Date

Comparisons of Direct Restorative Dental Materials

Comparative Factors	Amalgam	Composite Resin (Direct and Indirect Restorations)	Glass Ionomer 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 and resin polymer and organic acid; self hardening by exposure to blue light.
Principle Uses	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 crowns, liners, temporary restorations.	Small fillings; cementing metal and porcelain/metal crowns, and liners.
Resistance to Further Decay	High; self-sealing characteristic helps resist recurrent decay; but recurrent decay around amalgam is difficult to detect in its early stages.	Moderate; recurrent decay is easily detected in early stages.	Low –Moderate; some resistance to decay may be imparted through fluoride release.	Low-Moderate; some 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; bonds adhesively to healthy 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. Fair in non-stress bearing applications.	Poor in stress-bearing applications; Good in non-stress bearing application.
Resistance to Fracture	Amalgam may fracture under stress; tooth around filling may fracture before the amalgam does.	Good resistance to fracture.	Brittle; low resistance to fracture but now recommended for stress-bearing restorations	Tougher than glassionomer; recommended for stress-bearing restorations in adults.
Resistance to Leakage	Good; self-sealing by surface corrosion; margins may chip over time	Good if bonded to enamel; may show leakage over time when bonded to dentin; Does not corrode.	Moderate; tends to crack over time.	Good; adhesively bonds to resin, enamel, dentine/post-insertion expansion may help 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 surfaces of adults; suitable for short-term primary teeth restorations.
Toxicity	Generally safe; occasional allergic reaction 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; recommended 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 slightly over time; predisposing to plaque accumulation and periodontal disease if the material contacts the gingival tissue.
Susceptibility to Post-Operative Sensitivity	Minimal; High thermal conductivity may promote temporary sensitivity to hot and cold; Contact with other metals may cause occasional and 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-Moderate; durable material hardens rapidly; some composite materials show more rapid wear than amalgam. Replacement is usually due to marginal leakage.	Moderate; slowly dissolves in mouth, easily dislodged.	Moderate; more resistant to dissolving than glass ionomer, but less than composite resin.
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 veneers and crowns)	Moderate; similar to composite resin (not used for veneers and crowns)
Number of Visits Required	Single visit (polishing may require a second visit)	Single visit for fillings; 2+ visits for indirect inlays, veneers and crowns.	Single visit.	Single visit.

Glossary of Terms

General Description – Brief statement of the composition and behavior of the dental material.

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, their 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, clenching, 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 now 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 material.

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 of stimuli (heat, cold, sweet, pressure) after the material is placed in them.

Esthetics – An 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 composed mainly of mercury (43-54%) and varying percentages of silver, tin, and copper (46-57%)

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X-Rays Consent Form

I understand that dental x-rays (radiographs) are a necessary part of the diagnosis process and consent to having any dental x-rays (radiographs), taken. I understand that the examination and diagnosis process involves x-rays (radiographs), oral cancer screening, and perio chart probing and I consent to this process. I understand that should treatment be diagnosed for me that I would be given the opportunity to ask any questions. Also, any fees associated with any treatment will be discussed with me at that time.

Print Patient's Name: _____

Date: _____

Responsible Party's Signature: _____ Relationship to Patient _____

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CANCELLATION POLICY

AN APPOINTMENT TIME AND ROOM HAS BEEN RESERVED FOR YOU. PLEASE NOTIFY THE OFFICE WITHIN 48 HOURS FOR CANCELLATION OR NEED TO RESCHEDULE. A \$50.00 FEE WILL BE INCURRED FOR ANY BROKEN APPOINTMENT.

OUR VOICEMAIL IS AVAILABLE 24 HOURS A DAY DURING WEEKENDS. YOUR HEALTH PLAN DOES NOT COVER FOR MISSED APPOINTMENTS.

PATIENT SIGNATURE

DATE