



MARIE E.C.S. ALEJANDRINO-BUELL, D.M.D., INC.

ACKNOWLEDGEMENT OF RECEIPT

_____ I acknowledge that I have received a copy of the **Dental Material Fact Sheet**.

_____ I acknowledge that I have received a copy of the **Notice of Privacy Practices**.

SIGNATURE OF PATIENT / PARENT OR GUARDIAN

SIGNATURE OF DENTIST / WITNESS

DATE

PATIENT INFORMATION

Confidential

Name: _____ SS# _____ - ____ - ____

I prefer to be called: _____ Birthdate: _____ Male Female

Check appropriate box Single Married Divorced Widowed Separated Minor

If patient is a minor, give name of parent or legal guardian _____ Relationship: _____

If patient is a student, name of school/college: _____

Address: _____

City: _____ State: _____ Zip: _____ E-Mail: _____

Home #: _____ Pager/Other #: _____

Fax #: _____

When & where are the best times to reach you ? _____

Whom may we Thank for referring you? _____

Other family members seen by us: No Don't Know Yes Name: _____

In the event of an emergency, is there someone who lives near you that we could contact?

Name: _____ Relation: _____

Work #: _____ Home #: _____

Previous/Present Dentist: _____

Last Visit Date: _____ Reason for leaving: _____

EMPLOYER AND INSURANCE INFORMATION

Employer: _____ Occupation: _____

Work phone #: _____ Ext: _____

Insurance Co.: _____ Group No.: _____

Coverage Family Self and Dependents Self Only

How much is your Annual Deductible? _____ Maximum Annual Benefit? _____

SPOUSE INFORMATION

His/Her Name: _____ SS# _____ - ____ - ____

Employer: _____ Occupation: _____

Work phone #: _____ Ext: _____ Birthdate: _____

Insurance Co.: _____ Group No. _____

Coverage Family Self and Dependents Self Only

Annual Deductible: _____ Maximum Annual Benefit: _____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 30 days. In the event of default I(We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

I grant permission to you or your assigns to contact me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signed: _____ Date: _____

HEALTH HISTORY

NAME: _____ DATE: _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Venereal Disease	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? _____ When did the treatment end? _____				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Please list any dietary or herbal supplements you are taking, and for what purpose:

- | | |
|-----------|-----------|
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |
| 11. _____ | 12. _____ |

Women: Are you pregnant? No Yes
 If no, are you planning a pregnancy in the near future? No Yes
 Are you a nursing mother? No Yes
 Are you taking birth control pills? No Yes

NAME: _____ DATE: _____

Abnormal Blood Pressure? (Please circle)

No Yes

Have you ever received a diagnosis of "high blood pressure"?

What is your normal blood pressure? S ___/D ___ Today: _____/_____/_____

Are you allergic or have you had a reaction to:

- a. Local anestheticsNo Yes
- b. Penicillin or other antibioticsNo Yes
- c. Aspirin, Ibuprofen or TylenolNo Yes
- d. Codeine, Valium® or other sedatives.....No Yes
- e. Latex or Metals.....No Yes
- f. Other (please specify) _____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies

Sugar in your diet (circle one): none slight moderate high

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

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

Patient (Print Name)

Patient Signature

Date

Doctor (Print Name)

Doctor Signature

Date

DENTAL HISTORY

Name _____ Date _____

Reason for visit: _____

How long since your:

- a. Last dental visit? _____
- b. Last cleaning? _____
- c. Last full mouth x-rays? _____

How often do you:

- a. Brush your teeth? _____
- b. Floss your teeth? _____

On a scale of 1 –10,

How would you rate your dental health? _____

How would you rate any pain you may be experiencing? _____

How would you rate your smile? _____

What would you change? Why? _____

Do you use tobacco in any form? Yes No

If so, which kind and how much? _____

Do you use alcoholic beverages (more than 2 drinks per day)? Yes No

Are you apprehensive to dental treatment? Yes No

Are you aware of grinding or clenching your teeth? Yes No

Do you have discolored teeth that bother you? Yes No

Are your teeth sensitive to hot/cold/sweets? Yes No

Have you ever had an unusual reaction to dental treatment? Yes No

Do you have pain in your jaws/head/neck? Yes No

Does food stick between your teeth? Yes No

Do your gums bleed when brushing/flossing? Yes No

Do you have a problem with bad breath? Yes No

I authorize Dr. Marie Buell to use/share this information and any records, photos and/or x-rays with other professionals for educational purposes.

Patient Signature

Date

Witness Signature

Date

Marie E.C.S. Alejandrino-Buell, D.M.D., INC.

1701 SOLAR DRIVE SUITE 180, OXNARD, CA 93030

Tel. No. (805) 981-3868/ Fax no. (805) 981-3869

PHYSICIAN/ DENTIST PATIENT ARBITRATION AGREEMENT

ARTICLE 1: Agreement to Arbitrate: It Is understood that any dispute as to medical /dental malpractice that is as to whether any medical /dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered will be determined by submission to arbitration as provided by California lay and not by a lawsuit or resort to court process except as California law provides judicial review of arbitration proceedings. Both parties to this contract by entering into it, are giving up their constitutional rights to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out or in any way relate to treatment or services provided or not provided by the below identified physician, dentist, medical group or association, their partners, associates associations, corporations, partnerships, employees, agents, clinics and/or providers (hereinafter collectively referred to as "physician") to a patient, including any spouse of heirs of the patient and any children.

Filing by Physician of any action in any court by the physician/dentist to collect any fee from the patient shall not waive the arbitration of any malpractice claim. However, following the assertion of any claim against Dentist, any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

ARTICLE 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician/Dentist, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues if liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure 1280-1295 and the Federal Arbitration Act (U.S.C. 1-4).
The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

ARTICLE 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by the Physician/ Dentist not only after the date is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

ARTICLE 5: Revocation: This agreement may be revoked by written notice delivered to Physician/Dentist within 30 days of signature and if not revoked will govern all medical services received by the patient.

ARTICLE 6: Severability Provision: In the event any provision(s) of this Agreement is declared coir and or/unenforceable, such provision(s) shall be deemed served there from and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL/ DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Patient's Signature (DATE)

Patient's Representative's signature

By: _____
Physician's/Dentist's Signature (Date)

Print Name and relationship to patient

Dr. Marie E.C.S. Alejandrino-Buell
1701 Solar Drive, Suite 180
Oxnard, CA 93030

FINANCIAL ARRANGEMENT AGREEMENT

Thank you for selecting our office for your dental care. WE are committed to the success of your treatment. Please understand that payment at the time of your treatment is considered a part of your commitment to our office.

In order to be impartial to everyone, **PAYMENT IS REQUIRED AT THE TIME OF TREATMENT.** We ask that you read and sign along with us, this statement prior to any treatment. Should you have any insurance benefits that we will be filing for you, **YOUR CO-PAY AND DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF TREATMENT.** We accept cash, check, debit cards, as well as ALL MAJOR CREDIT CARDS. For extensive treatment plans, we offer extended payment plans with Health Credit Card options at either little or NO interest with prior credit approval.

REGARDING INSURANCE

We will gladly file all dental claims for the given treatment. We are a NON-RESTRICTIVE provider for most insurance companies. The balance is **YOUR** responsibility whether your insurance carrier pays for your treatment or not. It is **YOUR** responsibility, that after **60** days without payment from your insurance carrier, the **TOTAL** balance due on the account is owed by you.

MISSED APPOINTMENTS

In order to be fair to all our patients, we ask that you notify our office at least **72 hours** in advance should you have a conflict with your scheduled appointment. Failure to contact the office or doctor will result with a charge of an office visit.

FINANCE CHARGES

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If the NCO Receivables Mgt. Co must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by the NCO.**

Thanks you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Financial Coordinator: _____ Date: _____

Patient 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

1432 Howe Avenue • Sacramento, California 95825

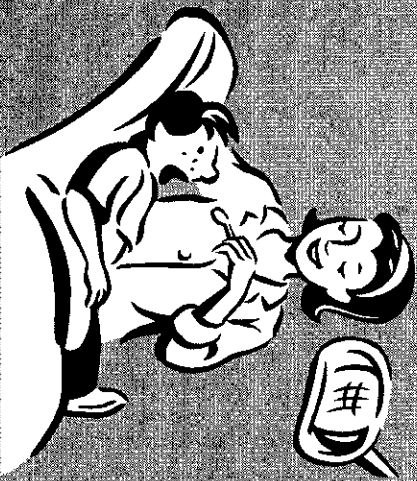
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5/04

The Facts About Fillings



*The Facts
About Fillings*

DENTAL BOARD OF CALIFORNIA
1432 Howe Avenue • Sacramento, California 95825
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



Dental Materials – Advantages & Disadvantages

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 Materials – Advantages & Disadvantages

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

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

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.



**DENTAL DESIGNS
DENTAL PRACTICE OF MARIE E.C.S. ALEJANDRINO-BUELL, D.M.D., INC.
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.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on **14 APRIL 2003** and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, **Marie Alejandrino-Buell**. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$25.00 for each page and the staff time charged will be \$20.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: DENTAL DESIGNS
Privacy Officer: Marie Alejandrino-Buell
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