Western Dental® & Orthodontics

Patient Information Sheet

DATE	
CHART #	

PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	DOB	SEX M F

SSN	ID TYPE (SELECT ONE) DRIVER'S LICENSE STATE ID FEDERAL ID PASSPORT OTHER	DRIVER'S LICENSE/ID #	ST

E-MAIL	HOME PHONE	CELL PHONE	WORK PHONE	PREFERRED LANGUAGE DECLINED TO SPECIFY

HOME ADDRESS	APT	CITY	ST	ZIP

EMPLOYER	POSITION	HOW LONG? YEAR MONTH

EMPLOYER ADDRESS	CITY	ST	ZIP

RESPONSIBLE PARTY (DISREGARD IF SAME AS ABOVE)

FIRST NAME	MI	LAST NAME	DOB	SEX M F	RELATIONSHIP TO PATIENT SELF SPOUSE OTHER PARENT

SSN	ID TYPE (SELECT ONE) DRIVER'S LICENSE STATE ID FEDERAL ID PASSPORT OTHER	DRIVER'S LICENSE/ID #	ST

E-MAIL	HOME PHONE	CELL PHONE	WORK PHONE	PREFERRED LANGUAGE DECLINED TO SPECIFY

HOME ADDRESS	APT	CITY	ST	ZIP

EMPLOYER	POSITION	HOW LONG? YEAR MONTH

EMPLOYER ADDRESS	CITY	ST	ZIP

MEDICAL CONTACTS: CURRENT DENTIST

DENTIST NAME	PHONE NUMBER

ADDRESS	CITY	ST	ZIP

EMERGENCY CONTACTS

CONTACT #1 FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	

E-MAIL	HOME PHONE	CELL	WORK PHONE

CONTACT #2 FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	

E-MAIL	HOME PHONE	CELL	WORK PHONE

PRIMARY INSURANCE

INSURANCE CARD PROVIDED

INSURED'S FIRST NAME	LAST NAME	

DOB	SEX M F	INSURED'S RELATIONSHIP TO PATIENT SELF SPOUSE OTHER PARENT

HOME ADDRESS	APT		

CITY	ST	ZIP	INSURED'S SSN

EMPLOYER	EMPLOYER'S PHONE NUMBER

INSURANCE COMPANY	INSURANCE COMPANY'S PHONE NUMBER

GROUP #	POLICY #

POLICY EFFECTIVE DATE	UNION NAME AND LOCAL UNION NUMBER

SECONDARY INSURANCE

INSURANCE CARD PROVIDED

INSURED'S FIRST NAME	LAST NAME	

DOB	SEX M F	INSURED'S RELATIONSHIP TO PATIENT SELF SPOUSE OTHER PARENT

HOME ADDRESS	APT		

CITY	ST	ZIP	INSURED'S SSN

EMPLOYER	EMPLOYER'S PHONE NUMBER

INSURANCE COMPANY	INSURANCE COMPANY'S PHONE NUMBER

GROUP #	POLICY #

POLICY EFFECTIVE DATE	UNION NAME AND LOCAL UNION NUMBER

INITIALS OF PATIENT	INITIALS OF RESPONSIBLE PARTY

Western Dental® & Orthodontics

Patient Information Sheet

DATE	
CHART #	

_____ INITIALS

Financial Responsibility: I understand that payments for services should be made when due, and if any payment is not made timely, I may be subject to late fees. I further understand that if I have authorized debits to my account and should a debit not be honored by my bank, I will incur a service charge for each such dishonored debit. I request that all benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the service provider. I understand that I am responsible for all charges for services whether or not paid by insurance. I authorize the service provider to disclose all information necessary to verify my insurance eligibility and secure the payment of benefits.

_____ INITIALS

Information Verification: The information provided herein is true and complete to the best of my knowledge. I authorize Western Dental (WD), or anyone acting on its behalf, to obtain, review and/or share with its designated agents, or any assignee of my account, my credit report for the purpose of evaluating my credit and verifying my identity, or for updating, renewing, servicing, modifying or collecting my account. This authorization is valid as long as any amounts are owed on my account to WD or any assignee of my account. I acknowledge that WD may report information about my account to consumer reporting agencies and other persons who may legally receive such information. Late payments, missed payments or other defaults on my account may be reflected in my credit report.

_____ INITIALS

Prior Express Consent for Calls/Texts/Email: By providing the number of my land line, cell phone or other wireless device and my email address now or in the future, I expressly consent and agree that WD and any of its affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system or otherwise, leave me a voice, prerecorded, or artificial voice message, or send me a text, e-mail, or other electronic message for any purpose related to the servicing or collection of any account that I may establish with WD, or for other informational purposes related to my account or treatment ("Communication"). I also agree that WD and any of its affiliates, agents, service providers or assignees may include my personal information in a Communication. WD will not charge for a Communication, but my service provider may. I agree that WD may monitor and record any telephone calls to assure the quality of its service or for other reasons.

_____ INITIALS

Broken Appointment Fee: I understand that it is important that I keep my scheduled appointments and if I miss an appointment without prior notification, I may be subject to a broken appointment fee.

Western Dental Services, Inc. ("WDS") will be using electronic medical records, including your photograph, to maintain your health care information. WDS is committed to maintaining the privacy and confidentiality of patient health information in compliance with HIPAA, and will only use your photograph for internal identification purposes.

You may, at any time, withdraw this consent with written notice to WDS.

_____ INITIALS

Yes. I agree to have my photograph taken and stored in WDS's electronic medical records system. I understand that by checking "Yes" and signing below, I am giving WDS permission to take and use my photograph in its electronic medical records system for identification purposes.

_____ INITIALS

No. I do not wish to have my photograph taken and stored in WDS's electronic medical records system.

By signing below, I acknowledge that I have read, fully understand, and agree to be bound by this consent.

_____ SIGNATURE OF PATIENT

_____ DATE

_____ SIGNATURE OF RESPONSIBLE PARTY

_____ RELATIONSHIP TO PATIENT

_____ DATE

HEALTH HISTORY

Patient First Name | MI | Last Name | Birthdate | Sex ☐ Male ☐ Female

GENERAL HEALTH QUESTIONS

1. Have you had any serious illness, operations or hospitalizations? ☐Yes ☐No

2. Are you under a physician's care at this time? ☐Yes ☐No

Name, address and phone # of physician:

Do you have or did you ever have any of the following?

Cardiovascular Health

3. High blood pressure ☐Yes ☐No
4. Angina or heart attack ☐Yes ☐No
5. Chest pain on physical exertion ☐Yes ☐No
6. Coronary artery blockage or treatment (bypass, stent, etc.) ☐Yes ☐No
7. Heart valve problem or replacement ☐Yes ☐No
8. Heart murmur ☐Yes ☐No
9. Heart disease, problem or treatment ☐Yes ☐No
10. Rheumatic fever ☐Yes ☐No
11. Past use of Fen-Phen ☐Yes ☐No
12. Irregular heart beat or pacemaker ☐Yes ☐No
13. Difficulty breathing when lying down ☐Yes ☐No
14. Stroke ☐Yes ☐No
15. Low blood pressure ☐Yes ☐No

Respiratory Health

16. Asthma ☐Yes ☐No
17. Emphysema or respiratory problems ☐Yes ☐No
18. Chronic sinus problems ☐Yes ☐No
19. Tuberculosis or persistent cough ☐Yes ☐No

Endocrine/Blood/Immune Health

20. Diabetes ☐Yes ☐No
21. Frequent thirst or frequent urination ☐Yes ☐No
22. Thyroid problems ☐Yes ☐No
23. Abnormal bleeding, bruise easily ☐Yes ☐No
24. Hemophilia ☐Yes ☐No
25. Anemia/blood disease ☐Yes ☐No
26. Cancer ☐Yes ☐No
27. Radiation therapy/chemotherapy ☐Yes ☐No
28. HIV infection/AIDS ☐Yes ☐No
29. Cold sores/canker sores ☐Yes ☐No
30. Organ transplant ☐Yes ☐No
31. Blood transfusion ☐Yes ☐No

Muscular-Skeletal/CNS/Mental Health

32. Joint replacement ☐Yes ☐No
33. Arthtritis ☐Yes ☐No
34. Osteoporosis ☐Yes ☐No
35. Fainting spells or dizziness ☐Yes ☐No
36. Seizures ☐Yes ☐No
37. Numbness or muscle weakness ☐Yes ☐No
38. Multiple sclerosis ☐Yes ☐No
39. Intellectual Disability ☐Yes ☐No
40. Dementia/Alzheimer's disease ☐Yes ☐No
41. Anxiety/Nervousness ☐Yes ☐No
42. Mental health treatment ☐Yes ☐No

Gastro-Intestinal/Genito-Urinary Health

43. Hepatitis (A, B, C or other) ☐Yes ☐No
44. Liver disease ☐Yes ☐No
45. Kidney disease/dialysis ☐Yes ☐No
46. Stomach trouble/ulcers ☐Yes ☐No
47. Sexually transmitted disease ☐Yes ☐No

Medication Allergies and Other Allergies

48. Penicillin or other antibiotics ☐Yes ☐No
49. Sulfa drugs ☐Yes ☐No
50. Dental antesthetic ☐Yes ☐No
51. Aspirin ☐Yes ☐No
52. Codeine/narcotics ☐Yes ☐No
53. Iodine ☐Yes ☐No
54. Latex products ☐Yes ☐No
55. Metals/nickels/jewelry ☐Yes ☐No
56. Other: _____

Females Only

57. Are you pregnant? ☐Yes ☐No
58. Are you nursing now? ☐Yes ☐No
59. Do you take birth control pills? ☐Yes ☐No

Medications

60. Are you taking any prescription medications, over the counter medications or herbal medicines? ☐Yes ☐No

If so, please list them and the dose taken:

_____

61. Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? ☐Yes ☐No

Social

62. Do you use tobacco? ☐ Yes ☐ No Quantity _____ Per Day
63. Do you use alcohol? ☐ Yes ☐ No Quantity ☐Per Day ☐Perweek
64. Do you use recreational drugs? ☐ Yes ☐ No Quantity Per Day
65. Do you have any other medical conditions not already listed above? ☐Yes ☐No

Please list:

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the unsigned, consent to the performing of x-rays and examination.

Signature of PATIENT or GUARDIAN _____ Date _____

Signature of DENTIST _____ ID# _____ Date _____

UPDATE Have there been any chan!'.jes in your medical history, includinA any medications that you take, since you last completed this form? ☐Yes ☐No

SiAnature of PATIENT or GUARDIAN _____ Date _____

SiAnature of DENTIST _____ Date _____

Western Dental SERVICES, INC.

ARBITRATION AGREEMENT

WAIVER OF RIGHT TO JURY TRIAL

Patient Name: _____ **Chart No:** _____ **Office Loc:** _____

Article 1: Agreement to Arbitrate Medical Malpractice And Other Disputes: It is understood that any dispute as to medical malpractice, that is as to whether any medical 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 a lawsuit or resort to court process except as California law provides for judicial review of 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.**

It is further understood that any dispute related to or arising from any charges, billings, payments, financing, debt collection, solicitations and/or marketing relating to any medical or dental services offered by or rendered by Western will be determined by submission to arbitration as provided pursuant to the terms outlined herein.

Article 2: All Claims Must Be Arbitrated: It is the intention and agreement of the parties that this arbitration agreement shall cover all claims or controversies relating to the matters described in Article 1 above, except claims within the jurisdiction of the Small Claims Court, whether in tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress, or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described in Article 1 may arise out of or in any way relate to treatment or services provided or not provided by Western Dental Services, Inc. ("Western") or any employee or agent or provider of Western, including any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. The undersigned understands and agrees that if the undersigned signs this Contract on behalf of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person.

The reference to Western includes the corporation, and its employees, agents and providers.

Article 3: Class Action Waiver: It is the intention and agreement of the parties that any arbitration brought pursuant to this agreement shall be conducted on an individual basis only, and not on a class, collective, or representative basis. There will be no right or authority for any dispute to be brought, heard or arbitrated as a class, collective, or representative action, or as a member in any purported class, collective, representative proceeding ("Class Action Waiver"). Disputes regarding the validity and enforceability of the Class Action Waiver may be resolved only by a civil court of competent jurisdiction and not by an arbitrator. In any case in which (1) the dispute is filed as a class, collective, or representative action and (2) a civil court of competent jurisdiction finds all or part of the Class Action Waiver unenforceable, the class, collective, and/or representative action to that extent must be litigated in a civil court of competent jurisdiction, but the portion of the Class Action Waiver that is enforceable shall be enforced in arbitration

Article 4: Procedures and Applicable Law: Patient shall initiate arbitration by serving a Demand for Arbitration on Western and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: General Counsel, Western Dental, 530 S. Main Street, Suite 600, Orange, CA 92868. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient and his/her attorney. Patient and Western agree that any arbitration hereunder shall be conducted by a single, neutral arbitrator selected by the parties and shall be resolved using the rules of the American Arbitration Association then in effect at the time the requirements are met for a demand for arbitration (located at https://www.adr.org/). (Arbitration, however, shall not be conducted by the American Arbitration Association and shall be conducted by an arbitration agency mutually selected by the parties). Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Civil Code §§ 3333.1 and 3333.2, Code of Civil Procedure §§ 340.5, 667.7, 1281-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1- 9), as in effect from time to time. The parties shall bear their own costs, fees, and expenses along with a pro-rata share of the arbitrator's fees and expenses.

Article 5: Retroactive Effect: Patient intends this Contract to cover services rendered by Western not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 6: Severability: If any provision of this Contract is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that this Contract is voluntary and that if I do sign it, I may rescind it only by giving written notice which must be delivered to and received by Western at the address outlined in Article 4 within 30 days of signature.

I understand that I have the right to receive a copy of this Contract. By my signature below, I acknowledge that I have read and understand the Contract, agree to its terms and have received a copy.

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

_____ _____ Date Signed: _____, 20 _____

Print Patient's Name (Signature of Patient, Parent, Guardian or Legally Authorized Representative of Patient)

WESTERN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing agreements under this Contract, Western likewise agrees to be bound by the terms set forth in this Contract and to the rules specified in Article 4 above.

_____ _____ Date Signed:_____, 20 _____

Prepared By Western Employee Print Name

A signed copy of this document is to be given to Patient. The Original is to be filed in Patient's dental chart.

Western® Dental

Acknowledgement of Receipt of:
Dental Materials Fact Sheet &
Western Dental's Notice of Privacy Practice

By signing this document, I acknowledge that I have received a copy of

☐ Dental Materials Fact Sheet

☐ Western Dental's Notice of Privacy Practice

NAME (PRINT)	SIGNATURE	DATE

FOR WESTERN DENTAL'S 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

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify): _____

_____

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 pre-sented concerning the filling materials being considered for your particular treatment.

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 indi-vidual is not in contact with the material.

There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porce-lain. 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 prob-lems with your dentist before a filling material is chosen.

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 main-ly 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 con-cerns 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 compro-mised.

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 den-tal amalgams. Questions have been raised about its safety in pregnant women, children, and diabetics. However, scientific evi-dence 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 chem-icals known to the state to cause cancer.

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

Dental Amalgam Fillings

Dental amalgam is a self-hardening mixture of silver-tin-copper alloy powder and liquid mercury and is some-times 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 overtime
- Requires removal of some healthy tooth
- In larger amalgam fillings, the remaining tooth may weaken and fracture
- Because metal can conduct hot and cold tem-peratures, there may be a temporary sensitivity to hot and cold
- Contact with other metals may cause occasion-al, minute electrical flow

The durability of any dental restoration is influenced not only by the material it is made from but also by the dentist's technique when placing the restoration. Other factors include the supporting materials used in the procedure and the patient's cooperation during the procedure. The length of time a restoration will last is dependent upon your dental hygiene, home care, and diet and chewing habits.

Composite Resin Fillings

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

Advantages

- ♥ Strong and durable
- ♥ Tooth colored
- ♥ Single visit for fillings
- ♥ Resists breaking
- ♥ Maximum amount of tooth preserved
- ♥ Small risk of leakage if bonded only to enamel
- ♥ Does not corrode
- ♥ Generally holds up well to the forces of biting depending on product used
- ♥ Resistance to further decay is moderate and easy to find
- ♥ Frequency of repair or replace-ment 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

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 compos-ite 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

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 restora- tion 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 restor- ation 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

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 restora- tion 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 porce-lain) 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

www.dbc.ca.gov

Joint Privacy Notice (State of California)
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 applies to the information and records we have about your health, health status, and the health care and services you receive at this office. 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 September 1, 2013, and will remain in effect until we amend or replace it.

If you have any questions about this Notice, complaints, or should you need to contact Western's Privacy Officer to comply with any provision of this Notice, please contact: Western's Privacy Officer, C/o Western Dental Services, Inc., P.O. Box 14227, Orange, CA 92863, Phone: (800) 417-4444. E-mail: PrivacyOfficer@WesternDental.com

Organizations covered by Joint Notice:

Western Dental Services, Inc.
Western Dental Plan

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment We may use and disclose your health information to provide you with medical treatment or services. We may also disclose your health information to other providers involved in your care.

For example, your doctor may be performing a tooth extraction and may need to know if you have other health problems that could complicate your treatment. The doctor may use your health history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

For Payment We may use and disclose health information about you to obtain payment for health care services we or others provide to you. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment and Refill Reminders; Prescription Information We may contact you by phone, mail, email, or other modes of communication as a reminder that you have an appointment for treatment or medical care at the office. We may also provide you with refill reminders or communicate with you about a drug or biologic that is currently prescribed to you so long as any payment we receive for making the communication is reasonably related to our cost of making the communication.

Treatment Alternatives We may contact you by phone, mail, email, or other modes of communication to inform you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services We may contact you by phone, mail, email, or other modes of communication to inform you about health-related products or services that may be of interest to you.

Surveys We may contact you by phone, mail, email or other modes of communication to ask you to participate in patient satisfaction surveys, or to provide you with other quality assessment and improvement communications.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety We may use and disclose health information about you when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law We will disclose health information about you when required to do so by federal, state or local law. For example, Western Dental may disclose information for the following purposes:

•For judicial and administrative proceedings pursuant to legal authority;
•To report information related to victim of abuse, neglect or domestic violence; and,
•To assist law enforcement officials in their law enforcement duties.

Research We may use and disclose health information about you for research projects if we receive special approval from a privacy board or institutional review board. Under certain circumstances, your health information may also be disclosed without your permission to researchers preparing to conduct a research project, for research on decedents or as part of a data set that omits your name and other information that can directly identify you.

Organ and Tissue Donation If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence We may use and disclose your health information to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances specified by law.

Workers' Compensation We may release health information about you in order to comply with the law and regulations related to workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities We may disclose health information to a health oversight agency. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with applicable laws.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena or other lawful process.

Law Enforcement We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors We may release health information to a coroner or medical examiner to enable them to carry out their lawful duties. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest.

In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

Marketing Except for marketing information given in a face-to-face encounter or promotional gifts of nominal value, we must obtain your written authorization prior to using your health information for purposes that are considered marketing under the federal health information privacy law commonly known as HIPAA. For example, we will not accept any payments from other organizations or individuals in exchange for making communications to you about treatment, therapies, health care providers, settings of care, case management, care coordination, products or services unless you have given us your authorization to do so or the communication is permitted by law.

Sale of Health Information We will not disclose your health information that is considered a sale of health information under HIPAA without your written authorization.

Sensitive Health Information There are special privacy protections under federal and state laws for certain sensitive health information, such as alcohol and drug abuse treatment information, HIV information, and mental health information (such as psychotherapy notes). We will not disclose your sensitive health information without your written authorization unless permitted or required by law. In addition, the Western Dental Plan will not use your genetic information for underwriting purposes.

Your Written Authorization We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization. If you give us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written

request to Western's Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies

Right to Amend If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Dental Record Amendment/Correction Form to Western's Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to Western's Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction unless the requested restriction is to a health plan for payment or health care operations purposes and the information you would like to restrict to the health plan pertains solely to a health care item or service you paid out of pocket. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the Request For Restriction On Use/Disclosure Of Medical Information to Western's Privacy Officer.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the *Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication to Western's Privacy Officer.* We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to be Notified of Breach You have the right to be notified by us if we discover a breach of your unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Copies of this Notice are available at Western's offices, or you may obtain a copy at our website at www.westerndental.com.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner and mail a copy to you.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Western's Privacy Officer. You will not be penalized for filing a complaint.