4215 Piedmont Avenue Oakland, CA. 94611 (510) 658-0110

PATIENT HISTORY AND PAYMENT ARRANGEMENT

(Necessary for your health and our records)

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____
Address: _____ City: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ E--Mail Address: _____
Birth Date: _____ Social Security Number: _____Driver License Number: _____
Employer: _____ Work Address: _____
Occupation: _____ Work Phone: _____ Marital Status: _____

GUARDIAN / SUBSCRIBER INFORMATION

First Name: _____ Last Name: _____ MI: _____
Address: _____ City: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ E--Mail Address: _____
Birth Date: _____ Social Security Number: _____Driver License Number: _____
Employer: _____ Work Address: _____
Occupation: _____ Work Phone: _____ Marital Status: _____

Employment Status	Full Time ☐	Part Time ☐	Retired ☐
Student Status	Full Time ☐	Part Time ☐	

How did you find out about our office? _____

EMERGENCY INFORMATION

1). Name: _____ Address: _____ Phone: _____
2). Name: _____ Address: _____ Phone: _____

I HAVE NO DENTAL INSURANCE

I elect to pay Cash ☐, Check ☐, MasterCard ☐, Visa ☐, American Express ☐, Discover ☐, at the time of service.

I HAVE DENTAL INSURANCE

I elect to pay my deductible and any out-of –pocket portion in full prior to scheduling for treatment.
I will be responsible to pay and balance not paid by insurance within 30 days.

Primary Insurance Information
Name of Insured _____
Insured Soc Sec: _____
Employer: _____
Address: _____
City, State, Zip: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Birth Date: _____
Ins. Company: _____
Ins. Address: _____
City, State, Zip _____

Secondary Insurance Information
Name of Insured _____
Insured Soc Sec: _____
Employer: _____
Address: _____
City, State, Zip: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Birth Date: _____
Ins. Company: _____
Ins. Address: _____
City, State, Zip _____

I understand and agree that (regardless of my Insurance status) I am ultimately responsible for the balance on my account. I have read and completed the foregoing information and certify that it is true and accurate. I request any and all treatment deemed necessary by the attending dentist and/or dentist/assistant, and agree to pay all charges for services rendered at the time of those services. I also authorize the release of any medical or other information about myself by any insurance company, or government authority that may be liable for payment of this claim and I hereby direct that any such payment be made directly to the dentist. I understand and agree that any charge that is unpaid shall be subject to an 18.5% APR, (monthly interest charge of 1.54%) and $5.00 billing charge. Should my account be assigned for collection, I will be responsible for all cost and attorney fee required to collect all money's due.

I will inform the doctor of any changes in my health or the above information.

The Dental Touch

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care?	○ Yes	○ No	If yes: _____
Have you been hospitalized or had a major operation?	○ Yes	○ No	If yes: _____
Have you had a serious neck or head injury?	○ Yes	○ No	If yes: _____
Are you taking any medications, pill, or drugs?	○ Yes	○ No	If yes: _____
Do you take, or have taken, Phen-Fen or Redux?	○ Yes	○ No	If yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes	○ No	If yes: _____
Are you on a special diet?	○ Yes	○ No	
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	If yes: _____
Do you snore?	○ Yes	○ No	
Does your bed partner snore?	○ Yes	○ No	
Have you been told you stop breathing while you sleep?	○ Yes	○ No	
Do you grind your teeth?	○ Yes	○ No	
Do you wear a nightguard?	○ Yes	○ No	
Do you wear a CPAP?	○ Yes	○ No	

Women: Are you…

❑ Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic
❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Local Anesthetics

Other allergy? ❑ Yes If yes: _____

Do you have, or have had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hep B or C ○ Yes ○ No	Rheumatism ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Hypertension ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Shingles ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy/Seizures ○ Yes ○ No	Hives/Rash ○ Yes ○ No	Sickle Cell ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Fainting/Dizziness ○ Yes ○ No	Irregular heartbeat ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Asthma ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Stroke ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Hyperglycemia ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cancer ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Problems ○ Yes ○ No	Tumors/Growths ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Ulcers ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	
Convulsions ○ Yes ○ No			

Have you ever had a serious illness not listed here? If yes: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X _____ Date: _____

Credit Card Authorization Form

As a courtesy to you, our staff will make inquiry of your benefits, complete the dental portion of the claims forms and coordinate your treatment plan to help you maximize your dental benefits. You will be expected to pay your portion in full at the time of service and we will require to have your credit card on file, for any reason your insurance does not pay the estimated amount, we will automatically transfer your remaining balance to your credit card or refund any difference. This will help avoid unnecessary billing and finances charges and prevent your account for being subject to collections. You may monitor this by reconciling your walkout statements from our office with the Explanation of Benefits (EOB) you receive from your insurance company. (You will receive your Explanation of Benefits (EOB) in the mail 2-3 weeks before our office receives a payment from your insurance company.)

Our computations of your benefits are based on the information your insurance company gave us during our inquiry. Barring any undisclosed clauses in your contract, this estimate should be accurate. The only way to increase accuracy is to submit a predetermination of benefits for the treatment proposed. However this could delay treatment 1-2 months or longer for your insurance company to process these forms. These delays have caused need for more extensive treatment and even though they may possibly increase accuracy the **insurance company will not guarantee their estimated payment**. Therefore, predeterminations are seen in this office as unnecessary delays and are of limited use, therefore will be done only by your request.

You will receive monthly statements informing you of any activity on your account as long as there is a balance, an 18.5% APR, (monthly interest charge of 1.54%) and $5.00 billing charge will be applied to all statements. Any accounts with balances 60 days or longer, **or** if for any reason your insurance company denies payment or pay less than the estimated amount, the balance will be automatically transferred to the credit card on file.

This is required for those patients that would like this office to accept the insurance portion of their claim as payment toward their balance. Without a credit card on file the full amount (co-payment and insurance portion will be due at time of service. Insurance payment will be directed or refunded to you as it becomes available.

All Credit card information will be Keep Strictly Confidential.

We are committed to protecting the security and integrity of customer information through procedures and technology designed for this purpose. We limit employee access to customer information to those who have a business reason to know. Employees are required to honor our code of conduct, which includes standards to protect customer confidentiality. We maintain policies and procedures covering the proper physical security of workplaces and records.

All balances not paid by your insurance company will be transferred to this card.

☐ **Visa** ☐ **MasterCard** ☐ **American Express** ☐ **Discover**

_____ _____ **CV Code**_____

Card Number **Exp. Date**

If any arrangements other then the above are necessary, please notify the receptionist. I understand and agree that (regardless of my insurance status). I am ultimately responsible for the balance on my account. I have read and completed the foregoing information and certify that it is true and accurate. I request any and all treatment deemed necessary by the attending dentist and/or dentist/assistant, and agree to pay all charges for services rendered at the time those services. I also authorize the release of any medical or other information about myself by any insurance company, or government authority that may be liable for payment of this claim, and I hereby direct that any such payment be made directly to the dentist. I understand and agree that any charge that is unpaid shall be subject to an 18.5% APR, (monthly interest charge of 1.54%) and $5.00 billing charge applied to all statements. Should my account be assigned for collection, I will be responsible for all costs and attorney fee required to collect all moneys due.

I will inform the doctor of any changes in my health or the above information.

Signature

Patient / Financially Responsible Party _____ Date: _____

Image Release

I hereby give my consent for the Health care providers of The Dental Touch to take photographs, slides and/or

video of _____ .
(Patient's name).

I also grant permission to reproduce, print and/or publish these images, in print or electronically, for use in articles, lectures, or advertisements.

I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record.

I do not expect compensation, financial or otherwise, for the use of these images.

I expressly authorize and grant a license to Dr. Dennis A. Prat, his business, organization, employees, or agents for any use of the above-stated images and expressly release and discharge Dr. Dennis A. Prat his business, organization, employees, or agents from any and all potential claims for the use of the above-stated images.

Please initial:

_____ I consent to the use of my photographs, slides, and/or video for articles, lectures, marketing, advertising, and laboratory use.

_____ I consent to the use of my photographs, slides, and/or video **ONLY** for laboratory use.

_____ I **DO NOT** consent to the use of my photographs, slides, and/or video.

I understand that the information disclosed under this authorization may be subject to disclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization.

I release and discharge Dr. Dennis A, Prat his business, organization, employees or agents from any and all claims or actions I have or may have relating to such use and publication.

_____ _____

Patient's or Legal Guardian's/Representative's Signature Date

WELCOME TO OUR OFFICE

Financial Policy
Thank you for choosing us as your dental care provider. We are committed to providing you with the finest services available. We feel our patients like to know our financial policy prior to any treatment. By doing so, this addresses many questions associated with your dental care. The Dental Touch is an Independent Contractor Association of doctors. Each doctor at this office is independent of each other and do not share in each other treatment liability. We feel this is an advantage to you as a patient because you can receive a completely independent second opinion under one roof. We encourage you as our patient to call or come by anytime you have a question regarding the treatment you receive by our staff, billing inquiries or quality of your care.

Estimates
We will be happy to discuss with you the estimated cost of the proposed treatment. Please keep in mind that this is an estimate and may not always be accurate. In some cases during treatment, there may be some unforeseen repairs and/or conditions discovered which could not be detected in the original estimate. If this should occur, we will cease all work immediately and obtain your authorization to continue. Other factors that may change the estimate may relate to your particular dental insurance coverage. If you have dental insurance please read the **Dental Insurance** section. We therefore, assume no liability for unforeseen repairs and/or conditions discovered during course of treatment nor any factors related to your insurance coverage. Estimated fees are subject to change after 90 days from the date of estimate.

Billing
Sending monthly statements are costly. In an effort to keep your dental costs down while maintaining a high level of professional care we have established the following payment options

1. Prepayment for a Complete Treatment Plan (after the full exam only) with your portion being **$1000.00** or more will receive a **5%** discount if paid in full at your first appointment. This is the only payment option that will protect your estimate against any fee increases during the course of your treatment.
(**This option is excluding from emergency treatment and any finance payment plans we offer in office to patient).**

2. Pay as you go through the treatment. A 50% deposit of your portion is due prior to being scheduled for your next appointment.

3. Payment plan with NO Finance or Interest charges for 12 months upon approval there is a set up fee from 5% to 11%.

4. Other extended payment plans are available up to 60 months (5 years) upon approval.

5. Sedation patients are required to pay for their treatment in full prior to their appointment.

6. A credit card number and photo ID on file are required for **ALL** patients that choose to pay for their services with a check.

Appointments
Once an appointment is made, please remember our Doctors and staff have reserved this time especially for you. Please notify us at least **48** hours in advance so other patients waiting for this time can be called. There will be a $1 per minute of appointments time added to your bill for a failed or canceled appointment without prior notification of **48** hours. A broken appointment is a loss to everyone.

Dental Insurance
Dental benefit plans are made available to employees or members, through companies, unions, and associations, and may vary considerably from one plan to the next. Most dental insurance are not designed to pay all of the cost of treatment, but rather to be a partial aid. The range of benefits depends solely on what the plan purchaser (your employer) can afford to offer employees or members.

Some plans base the amount of benefits on a chart or schedule of fees arbitrarily developed by third-party payers (the insurance company) and is independent of any schedule of fee at any dental office. For this reason, you may receive a lower percentage of the reimbursement level indicated in your dental plan.

Our fees are based on the costs of providing services in our practice, the treatment plan selected, and the time it takes us to provide you with the necessary dental care. The type of treatment you need and receive from our office is based upon our professional judgment. We are more than happy to discuss a treatment plan's advantages, disadvantages, alternatives and choices of materials used to complete your case. (Included with this material is a copy of **The Dental Material/Fact Sheet**, thereby involving you, not the third-party payer in the decision-making process.

If, after our discussion, you believe that the dental benefits provided by your plan are inadequate, you may want to discuss the matter with your employer, union, or association, so that appropriate alternatives can be investigated. Or check with the American Dental Association web site; *http://www.ada.org/en/public-programs/dental-benefit-information-for-employers/direct-reimbursement-plan/how-direct-reimbursement-works*

As a courtesy to you, our staff will make inquiry of your benefits, complete the dental portion of the claims forms and coordinate your treatment plan to help you maximize your dental benefits. You will be expected to pay your portion in full at the time of service and we will require to have your credit card on file, for any reason your insurance does not pay the estimated amount, we will automatically transfer your remaining balance to your credit card or refund any difference. You may monitor this by reconciling your walkout statements from our office with the Explanation of Benefits (EOB) you receive from your insurance company. (You will receive your Explanation of Benefits (EOB) in the mail 2-3 weeks before our office receives a payment from your insurance company.)

Our computations of your benefits are based on the information your insurance company gave us during our inquiry. Barring any undisclosed clauses in your contract, this estimate should be accurate. The only way to increase accuracy is to submit a predetermination of benefits for the treatment proposed. However this could delay treatment 1-2 months or longer for your insurance company to process these forms. These delays have caused need for more extensive treatment and even though they may possibly increase accuracy **the insurance company will not guarantee their estimated payment**. Therefore, predeterminations are seen in this office as unnecessary delays and are of limited use, therefore will be done only by your request.

You will receive monthly statements informing you of any activity on your account as long as there is a balance, a billing fee and 18.5% APR finance charge will be apply to all statements. Any accounts with balances 60 days or longer, or if for any reason your insurance company denies payment or pay less than the estimated amount, the balance will be automatically transferred to the credit card on file.

YOU ARE SOLEY RESPONCIBLE FOR THE ENTIRE BALANCE ON YOUR ACCOUNT EVEN IF THE INSURANCE DOES NOT PAY WHAT THEY STATED THEY WOULD.

We will provide information you request so that you can retort your insurance company but we accept no responsibility to your insurance company’s reimbursement.

Our office is committed to helping you achieve and maintain optimal dental function and health. Through the standard ADA approved claim form, we will accurately inform your insurance carrier of our treatment and fees.

"I have read, understand and agree to the provisions of this Financial Policy." Your signature will be requested at the end these forms.

The Dental Materials/Fact Sheet,
Comparisons of Direct Restorative

TYPES 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 & 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 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.	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	Poor in stress-bearing applications; Good in non-stress bearing applications.
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 not recommended for stress-bearing restorations.	Tougher than glass ionomer, 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, dentin/positive 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 reactions to metal components. However amalgam contains mercury. Mercury in its elemental form is toxic and as such is listed on prop 65.	Concerns about trace chemical release are not supported by research studies. Safe; no known toxicity documented. Contains some compounds listed on prop 65	No known incompatibilities. Safe; no known toxicity documented.	No known incompatibilities Safe; no known toxicity documented.
Allergic or Adverse Reactions	Rare; recommend that dentist evaluate patient to rule out metal allergies	No documentation for allergic reactions was found	No documentation for allergic reactions was found. Progressive roughening of the surface may predispose to plaque accumulation and periodontal disease	No know 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; Contact6 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, get 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 of Replacement	Low; replacement is usually due to fracture of the filling or the surrounding tooth.	Low-Moderate; durable material hardens rapidly; some composite material 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 filings; actual cost of fillings depends upon their size; veneers and 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 visits (polishing may require a second visit)	Single visit for fillings; 2+ visits for indirect inlays, veneers	Single visit	Single visit

Comparisons of Indirect Restorative

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

NOTICE OF PRIVACY PRACTICES

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 (04/14/2003), 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 applicable law permits such 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

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

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

Healthcare Operations: We may use and 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 an authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your healthcare 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Abuse and Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forced personnel under certain circumstances. We may disclose to authorized, federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional 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).

PATIENTS 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 form 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. If you request copies, we will charge you $1.25 for each page, $25.00 per hour for 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 associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 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 under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or has 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 you health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us 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 a complaint with us or with the U.S. Department of Health and Human Services.

Telephone: **510-658-0110**

Address: **The Dental Touch**
4215 Piedmont Avenue
Oakland, CA 94611

I have to the best of my knowledge, the questions on the Patient History and Payment Arrangement, Medical History and other attached forms have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health.

It is my responsibility to inform the dental office of any changes in medical status or my personal or insurance billing information.

I have read, understand and agree to the provisions of this Financial Policy and the use of the Credit Card authorization for payment of balances due. I understand that I am solely responsible for the entire balance on your account even if the insurance does not pay what they stated they would.

I acknowledge the receipt of the Notice of Privacy Practices and the Dental Materials/Fact Sheet forms.

Signature

Print Name_____ **Date**_____