PATIENT INFORMATION

*(This information is necessary for our files and will be considered **CONFIDENTIAL**)*

Date _____

Patient's Name _____ Age ____ Patient's Birthday _____ ❑ Male ❑ Female
LAST FIRST INITIAL

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

Residence Address _____ For how long? ____ ❑ Own ❑ Rent
STREET CITY ZIP

Patient is: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Minor E-mail _____

Driver's License No. _____ Social Security No. _____ Res. Phone (____) _____

Bank _____ Account No. _____ How long? _____ Cell Phone (____) _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ Bus. Phone (____) _____
STREET CITY ZIP

Spouse's Name _____ Driver's License No. _____ Soc. Sec. No. _____

Employed by _____ How long? Occupation _____

Business Address _____ Bus. Phone (____) _____
STREET CITY ZIP

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Res. Phone (____) _____
STREET CITY ZIP ❑ I have no physician

Name of Physician _____ (____)
ADDRESS CITY TELEPHONE

Former Dentist _____ (____)
ADDRESS CITY TELEPHONE

Why are you changing dentists? _____

Purpose of Appointment _____ Do you wish to speak to the doctor privately? ❑ Yes ❑ No

Is this office visit for Emergency Dental Care? ❑ Yes ❑ No If yes, explain: _____

School Children Attend _____ Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____ (____) _____
TELEPHONE

Address _____ (____) _____
STREET CITY ZIP CELL PHONE

PREFERENCE OF PAYMENT: ❑ Cash on day of treatment ❑ Visa No. _____
EXPIRATION DATE

❑ State Aid No. _____ ❑ Mastercard No. _____
EXPIRATION DATE

Name of insurance company (primary insurance) _____

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION LOCAL

Name of insurance company (secondary insurance) _____

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION LOCAL

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, to telephone 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 QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? ..... (Yes) No

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Date of last physical examination _____
3. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ..... Yes No
   If so, what illness or operation? _____
5. Have you ever been hospitalized? ..... Yes No
   If so, what was the problem? _____
6. Are you taking any ❑ medications, ❑ drugs or ❑ herbs? ..... Yes No
   If so, what? _____ What dosage? _____
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? ❑ Yes ❑ No If so, what? _____
8. Have you ever been pre medicated with antibiotics for your dental treatment? ..... Yes No
9. Are you sensitive or allergic to any drugs or materials? ❑ Penicillin; ❑ Tetracycline; ❑ Sulfa Drugs; ❑ Aspirin; ❑ Codeine; ❑ Latex; ❑ Other ..... Yes No
   If Other, what drugs? _____
10. Do you have or have you had any of the following: (Please circle 'Y' for Yes or 'N' for No - answer all conditions):

Y N Anemia	Y N Glaucoma	Y N Sleep Apnea	Y N Angina Pectoris	Y N Pain in Jaw Joints	Y N Psychiatric Treatment
Y N Herpes	Y N Tonsillitis	Y N Snoring	Y N Mental Disorder	Y N Artificial Prosthesis	Y N Hepatitis or Jaundice
Y N Stroke	Y N Hemophilia	Y N Heart Murmur	Y N Thyroid Disease	Y N Sickle Cell Disease	Y N Difficulty Swallowing
Y N Ulcers	Y N Cold Sores	Y N Liver Disease	Y N Fainting Spells	Y N Cortisone Medicine	Y N Congenital Heart Lesions
Y N Diabetes	Y N Emphysema	Y N Blood Disease	Y N Rheumatic Fever	Y N Allergies to Metals	Y N Osteoporosis
Y N Arthritis	Y N Rheumatism	Y N Heart Ailments	Y N Tuberculosis (T.B.)	Y N Excessive Bleeding	Y N X-Ray or Cobalt Treatment
Y N Asthma	Y N Chicken Pox	Y N Heart Attack	Y N Blood Transfusion	Y N Mitral Valve Prolapse	Y N Radiation Treatment of any kind
Y N Cancer	Y N Bruise Easily	Y N Cerebral Palsy	Y N Low Blood Sugar	Y N High Blood Pressure	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Seizures	Y N Head Injuries	Y N Drug Addiction	Y N Joint Replacement	Y N Low Blood Pressure	Y N Acquired Immune Deficiency Syndrome (AIDS)
Y N Hay Fever	Y N Heart Failure	Y N Kidney Disease	Y N Nervous Disorders	Y N HIV Related Complex	Y N TMJ (Temporomandibular Joint) Disorder
Y N Headaches	Y N Scarlet Fever	Y N Chemotherapy	Y N Tumors or Growths	Y N Respiratory Disease	
Y N Implant (s)	Y N Sinus Trouble	Y N Stomach Ulcers	Y N Allergies or Hives	Y N Epilepsy or Seizures	

Y N Other _____ _____ _____ _____ _____

11. Do you have any disease, condition or problem not listed that you think we should know about? ..... Yes No
    If so, what? _____
12. Do you wear a cardiac pacemaker, or have you had heart surgery? ..... Yes No
13. Do you smoke? If yes, how much? _____ ❑ Cigarettes ❑ Cigars ❑ Packs per day ..... Yes No
14. Have you ever taken the drugs ❑ Fen-Phen, ❑ Redux, ❑ Fosamax (Bisphosphonate), ❑ Zometa, ❑ Actonel, ❑ Boniva, ❑ Aredia, ❑ Diet Drugs? ..... Yes No
15. (Women) Are you pregnant? If so how many months? _____ Yes No
16. (Women) Do you have any problems associated with your menstrual period? Yes No
17. (Women) Do you take any birth control medication or hormones? ..... Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? ..... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
   If so, explain? _____
4. How long since your last full mouth X-Rays? _____ Weeks _____ Months _____ Years
5. How long since your last dental treatment? _____ Weeks _____ Months _____ Years
6. Does dental treatment make you nervous? ❑ Slightly ❑ Moderately ❑ Extremely? ..... Yes No
7. Would you desire to be pre-sedated? ..... Yes No

❑ I hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changes in any way. ❑ Patient refused / was unable to sign because _____.

❑ I have received a copy of the **Dental Materials Fact Sheet** as required by law.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Ⓐ **Date** _____ **Signature** _____

Reviewed by _____ Lic. # _____ Date _____

Ⓑ ***UPDATE — Since your last visit Ⓐ:***

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in your medication? ..... Yes No
3. Have you had a change in your medical condition or had surgery? ..... Yes No

Please note changes in health since last visit. If no changes, please write "None"

_____

Date _____ **Signature** _____

Ⓒ ***UPDATE — Since your last visit Ⓑ:***

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in your medication? ..... Yes No
3. Have you had a change in your medical condition or had surgery? ..... Yes No

Please note changes in health since last visit. If no changes, please write "None"

_____

Date _____ **Signature** _____

REVIEWED BY	DO NOT WRITE IN THIS SPACE			
Ⓐ DATE _____		Ⓐ	Ⓑ	Ⓒ
Ⓑ DATE _____	DATE			
Ⓒ DATE _____	B.P.	/	/	/
	PULSE			
	TEMP			
	BY			

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed: _____ **Date:** _____ **Relationship to Patient** _____

CREDIT CARD AUTHORIZATION FORM

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check-in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Nairi Kureghian, D.D.S

I, _____, authorize Dr. Nairi Kureghian, D.D.S. to charge outstanding balances on my account to the following credit card:

Visa MasterCard Care Credit Other: _____

Account Number: _____ Expiration Date: _____

Name on Card (Please Print): _____

Signature: _____ Date: _____

Nairi Kureghian, D.D.S., Inc.

ASSIGNMENT OF BENEFITS

I hereby assign to Dr. Nairi Kureghian, DDS. Inc., all my right, title, and interest in and to any and all dental benefits otherwise payable to me for oral health treatment rendered by the assignee on _____ as described in the attached claim form.

I acknowledge that I am still responsible for paying the above-referenced dentist to the extent the relevant insurer or payor does not pay the dentist in full.

Policy name: _____ Policy Number: _____

Patient Name: _____ Dated: _____

Patient's Signature: _____

If not signed by the patient, please indicate relationship:

- ☐ Patient or guardian or minor patient (to the extent minor could not have consented to the care)
- ☐ Guardian or conservator of patient
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

Nairi Kureghian, D.D.S., Inc.

COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

I, _____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing. Our office is adhering to the CDC, OSHA and ADA guidelines to prevent the spread of the virus. Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus.

Initials: _____

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below: Fever; Shortness of Breath; Loss of sense of taste or Smell; Dry Cough; Runny Nose; Sore throat

Initials: _____

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus and the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has traveled recently, and this is not possible with dentistry.

Initials: _____

I understand that due to the frequency of visits of others dental patients, the characteristics of the virus, and the characteristics of dental procedures that I may have an elevated risk of contracting the virus simply by being in a dental office. I also acknowledge that I could contract the Covid19 virus from outside this office and unrelated to my visit here.

Initials: _____

I verify that I have not traveled outside the United Stated in the past 14 days to countries that have been affected by COVID-19.

Initials: _____

I verify that I have not traveled domestically within the United States by commercial airlines, bus, or train within the past 14 days.

Initials: _____

Although there are no guarantees regarding the possibility of contracting COVID-19, my dentist and the staff will be following safety protocols as to best protect myself and the staff during treatment. I understand that I have the possibility to delay my treatment, and I have elected to have the procedure at this time.

Initials: _____

I will report if I am diagnosed or develop Covid19 signs/symptoms within 2 days after my dental appointment.

Initials: _____

Patient Name: _____

Patient Signature: _____ Date: _____

SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. **PROCESS ALL INSURANCE CLAIMS.**
2. **ENSURE PAYMENT FOR SERVICES PROVIDED.**
3. **RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS.**
4. **RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to DOCTOR/PRACTICE NAME. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Parent Signature: _____

Patient Full Name (Please Print): _____

Parent Signature (if minor): _____

Witness: _____

Date Signed: _____

FINANCIAL RESPONSIBILITY

Many patients have a commonly held misconception that medical and dental benefit policies that their employers, or they individually, have purchased will pay for all of their treatment. THAT IS INCORRECT AND UNTRUE.

As a patient in this office, you will receive treatment that is specific to the problems that are noted during your examination. Your doctor will carefully review his/her findings with you and explain to you the treatment options (if any) that are available to you. In return, your financial responsibility for the treatment that you agree to will be to the doctor's office. We will be glad to assist you in obtaining reimbursement for part of these benefits from your medical and/or dental insurer.

Often insurance companies, upon the patient's request, will send benefit reimbursement directly to the doctor's office. Please understand that your benefits contract will always have an allowable benefit payment for each procedure performed and that allowable benefit is determined by the limitations of the contract that your employer or you personally have purchased from the insurer and does NOT always equal the doctor's submitted fee. Your insurance plan will pay only a percentage of the allowable benefit your employer or you have bought as part of your plan with a co-payment portion then being assigned to you. You are responsible to your doctor for payment of your yearly deductible, if not already satisfied, the patient co-payment portion, and any remaining portion of your doctor's bull that is not covered by your insurance plan.

We will be happy to discuss with you the financial arrangements for the payment of your bull, whether or not you have medical/dental insurance available to you. Please understand that third party payment is NOT a guarantee of benefits payment, even though you may feel that you have the coverage under your insurance policy(-ies). Financial responsibility for all services received at this office is yours alone. We will gladly work with you to arrange payment for services provided, and these arrangements will be set up on an individual-needs basis.

Thank you for your confidence in our office and our doctors. We look forward to providing you with competent care and courteous service.

Sincerely,

Dr. Nairi Kureghian, DDS

I HAVE READ THE ABOVE FINANCIAL RESPONSIBILITY STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO **DR. NAIRI KUREGHIAN, DDS, INC** also referred to as **THE MASTERPIECE SMILES** FOR ALL CARE AND SERVICES PROVIDED TO ME.

Patient Name: _____ Date: _____

Signature: _____ Witness: _____

Nairi Kureghian, D.D.S., Inc.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ E-mail: _____

Patient No.: _____ Social Security No.: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment payment activities, and healthcare operations.

Notice Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dr. Nairi Kureghian, DDS
18250 Roscoe Blvd., Ste. 355
Northridge, CA 91325
Phone: (818) 701-6197 | Fax: (818) 701-6198
Email: office@drnairi.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Dr. Nairi Kureghian, DDS (listed above). Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

I, (Patient Name) _____, have had full opportunity to read and consider the contents of this Consent firm and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Nairi Kureghian D.D.S., Inc.

GENERAL DENTISTRY INFORMED CONSENT

Patient: _____

1. **Work To Be Done**
   I understand that I am having the following work done: **(Initials)** _____

- X-Ray ☐
- Exam ☐
- Cleaning ☐
- Fillings ☐
- Crowns ☐
- Extractions ☐
- Impacted teeth removed ☐
- Root Canals ☐
- Dentures ☐
- Veneers ☐
- Implants ☐
- Bridges ☐
- Whitening ☐
- Other _____

2. **Drugs and Medications**
   I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock.

(Initials) _____

3. **Changes in Treatment Plan**
   I understand that during treatment it may be necessary to change or add procedures because of conditions that were not discovered during examinations, but we found while working on teeth. For example, root canal therapy may be discovered to be needed during routine restorative procedures. I Give My Permission To The Dentist To Make Any/All Changes and Additions As Necessary.

(Initials) _____

4. **Removal of Teeth**
   Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some are which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is My Responsibility.

(Initials) _____

5. **Crowns, Bridges, Caps, Veneers, Inlays, Onlays**
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary restorations, which may come off easily and that I must be careful to ensure that they are kept on until the permanent restorations are delivered. I realize the final opportunity to make change in my new restorations (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the restorations. I understand there will be additional charges for remakes due to my delaying permanent cementation.

(Initials) _____

6. **Endodontic Treatment (Root Canal)**
   I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filing material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost despite all effort to save it.

(Initials) _____

7. **Periodontal Loss (Tissue and Bone)**
I understand that I have a serious condition causing my gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials) _____

8. **Fillings**
I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

(Initials) _____

9. **Dentures**
I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjustable, and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that my responsibility to return and delivery of the dentures. I understand that the failure to keep my delivery appointed may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.

(Initials) _____

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that no other Dentist is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that his is only an estimate and subject to modification depending on unforeseen or diagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1966 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE SUED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to endure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey, we may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing except that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

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

Nairi Kureghian, D.D.S., Inc.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, (Patient Name)_____, have received a copy of this Office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

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

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

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

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

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

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at: (800) 232-7645.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

Frequently-Asked-Questions

Dental Board
DENTAL MATERIALS FACT SHEET AND SB 134
November 2001

What is the Dental Materials Fact Sheet (DMFS)?

A state law passed in 1992 required the Dental Board of California to develop and distribute a fact sheet describing and comparing the risks and efficacy of the various types of dental restorative materials that may be used to repair a dental patient's oral condition or defect. The fact sheet is intended to encourage discussion between patient and dentist regarding materials and to inform the patient of his or her options.
(Refer to Business & Professions Code section 1648.10.)

The fact sheet was first distributed in 1993, and used information published in the 1993 U.S. Public Health Service report on the safety of amalgam. The Dental Board approved an updated fact sheet in October 2001. An independent consultant reviewed an extensive number of pertinent, peer-reviewed scientific articles in the course of updating the DMFS. While more detailed, the information contained in the new fact sheet does not differ substantially from the 1993 fact sheet.

How do I get a copy of the DMFS?

The Dental Board mailed the DMFS to all licensed dentists in mid-November. You also can obtain a copy at the Dental Board web site at www.dbc.ca.gov, or by contacting them at (916) 263-2300.

What do I do with the DMFS?

Senate Bill 134, signed by the governor in October, requires that beginning January 1, 2002, each dentist is provide a copy of the DMFS to any patient prior to commencing any dental restorative work. This requirement applies to new patients and patients of record. The dentist is required to obtain a signed acknowledgement that the patient has received the fact sheet, and a copy of the acknowledgement must be placed in the patient's record.

The dentist need only provide the DMFS one time to each patient. If the DMFS is updated, the dentist then is required to provide the updated DMFS to all patients prior to commencing any dental restorative work and to obtain again a signed acknowledgement of receipt.

This new requirement was prompted by a belief that the earlier version had not been routinely discussed with patients, and therefore the requirement was added to SB 134.

Is there a specific form I need to use for the acknowledgment, or can I prepare my own?

The Dental Board has not created a form at this time. CDA recommends you create a form that includes a statement such as:
"I, (a blank line to insert the patient's name) acknowledge I have received from (name of dentist or dental office) a copy of the Dental Materials Fact Sheet dated October 2001."

The form should include blank lines for the patient's signature and the date. You may want to place on the bottom of your form a copy of the top half of the first page of the fact sheet. This provides a visual reference for the patient.

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I acknowledge that I have received a copy of the Dental Materials Fact Sheet dated October 17, 2001.

Patient Signature

_____

*Date*_____

I don't place amalgams - am I exempt?
No. The law specifically states it should be provided "prior to the performance of dental restoration work." This includes fillings - whether amalgam or composite, crowns and bridges, inlays and onlays, yeneers, implants.

Obtaining the patient acknowledgement and dealing with patient questions will take time.

Yes, it will take time. However, the DMFS has existed since 1993 with the understanding that dentists would review dental material options with their patients. Obtaining the acknowledgment is a new requirement. Reviewing with patients the options in dental restorative materials is not new. Reviewing this information should be viewed as an opportunity to educate patients and to enhance credibility with your patients.

Is the acknowledgement the same as informed consent?

No, It Is not Informed consent is a legal doctrine that requires a health care provider to obtain a voluntary consent from a patient to proceed with a dental treatment after the patient has been informed of the risks, benefits, and alternatives to the dental treatment The fact sheet is an educational tool not a document requiring permission to proceed with treatment.

How often do I have to provide the DMFS to patients?

You provide it once to each patient prior to starling any restorative work. If the Dental Board updates the DMFS, the dentist must provide an updated DMFS to every patient and again obtain a signed acknowledgment.

What if I disagree with the DMFS, do I have any options?

There is no alternative to this requirement.

How do I find out if the DMFS has been updated?

The Dental Board and CDA will inform you when it is updated and where to obtain an updated copy.

###

CDA CONSUMER & MEDIA NFORMAT1ON BUREAU
1201 K Street Mall, Sacramento, CA 95814
Phone: 916/443-3382, Ext. 4670