



Patient Information & Practice Agreement

We would like to extend a warm welcome to Studio B Smiles the dental office of Dr. John Badolato and Associates. We are a full-service general and cosmetic dental practice. Studio B Smiles offers a wide array of services ranging from basic exams to complete smile makeovers. The doctors and team at Studio B Smiles strive to provide excellent clinical care as well as an unparalleled level of customer service. While we do accept certain insurance plans, we do not allow insurance to dictate treatment. In this office, your best interest is the only interest we will consider. We look forward to providing you with excellent dental care for many years to come.

____ Dr. ____ Mr. ____ Mrs. ____ Ms.
Full Name: _____
I prefer to be called: _____
Who referred you to us: _____
____ Single ____ Married ____ Divorced ____ Widowed
Birth date: ____/____/____ ____ Male ____ Female
Social Security Number: _____
Address: _____
City: _____ State _____ Zip _____
Email Address: _____
Home Number: (____) _____
Cell/Other: (____) _____
Where and when is the best way to reach you? _____

Occupation: _____
Employer: _____
Employer's Address: _____
Work Number: (____) _____ Ext. _____
Spouse/Partner: _____
Spouse's Occupation: _____
Spouse's Employer: _____
In the event of an emergency, who should we contact?
Name: _____
Relation to you: _____
Work Number: (____) _____
Home Number: (____) _____
Cell Number: (____) _____

In the event that we cannot reach you directly, do you authorize Studio B Smiles to leave a message for you? Yes No

Insurance Information

Primary Dental Insurance Company: _____
Primary Subscriber Name: _____
Subscriber ID Number: _____
Subscriber Date of Birth: _____
Group Number: _____
Insured's Employer: _____
Insurance Co. Telephone Number: _____
Insurance Claim Address: _____

Primary Medical Insurance Company: _____
Primary Subscriber Name: _____
Subscriber ID Number: _____
Subscriber Date of Birth: _____
Group Number: _____
Insured's Employer: _____
Insurance Co. Telephone Number: _____
Insurance Claim Address: _____

Do you have secondary dental insurance? Yes No

Do you have secondary medical insurance? Yes No

At Studio B Smiles, we realize how important insurance benefits are. We ask that **you** carefully review your policy and/or contact your insurance carrier, so that **you** are aware of benefits, frequencies, limitations, and/or restrictions. **Please be informed that YOUR dental insurance is a contract between YOU and YOUR insurance company. Our role is to simply assist you with filing your claims.** While we will obtain a summary of benefits from your insurance *it is up to you* to know the frequencies, limitations and/or restrictions of your plan. It is your responsibility to provide us with any changes in your insurance. If any dental services have been provided to you by any other provider within the existing benefit year, please advise us. **Any portion of treatment that your dental insurance does not pay will be your responsibility.**

Dental Health

Please provide information on the last dentist you have seen:

Name _____

Phone Number (____) _____

Date Range Seen: _____

Types of Treatment: _____

What is the primary reason you came to our office today?

Are you currently experiencing any pain/discomfort? Yes No

Current Dental Health: Good Fair Poor

Does food catch between your teeth? Yes No

Are your teeth sensitive to cold or sweets? Yes No

Any unpleasant experiences in a dental office? Yes No

If yes, please explain: _____

Are your teeth somewhat yellowed, darkened or stained? Yes No

Have you ever experienced pain or discomfort in your jaw joint? (TMJ/TMD) Yes No

Are there spaces between any of your teeth? Yes No

Do you grind your teeth or are any of the biting edges on your teeth chipped or worn down? Yes No

Do you have a "gummy" smile—showing too much gum tissue or having gums that are too thick? Yes No

Are your gums red, puffy or do they bleed? Yes No

Do you have an gray, black or silver (mercury) dental fillings in your teeth that you want to replace? Yes No

Do you have any old crowns that have dark edges at the top that don't really look natural? Yes No

Do you smoke? How much/often? _____

Do you use smokeless tobacco? How much/often? _____

Do you drink alcohol? How much/often? _____

Medical History

Have you ever had any of the following illnesses or medical problems in the past. Please check Yes or No.

Y | I | N

____|____|____ Abnormal Bleeding

____|____|____ Alcohol/Drug Abuse

____|____|____ Allergies

____|____|____ Anemia

____|____|____ Arthritis

____|____|____ Artificial Bones/Joints/Valves

____|____|____ Asthma

____|____|____ Athletes Foot

____|____|____ Blood Transfusion

____|____|____ Bone/Joint Disease

____|____|____ Bursitis

____|____|____ Cancer/Chemotherapy

____|____|____ Colitis

____|____|____ Congenital Heart Defect

____|____|____ Diabetes

____|____|____ Difficulty Breathing

____|____|____ Eating Disorders

____|____|____ Emphysema

____|____|____ Epilepsy

____|____|____ Fainting Spells

____|____|____ Frequent Headaches

____|____|____ Gingivitis

Y | I | N

____|____|____ Periodontal Disease

____|____|____ Glaucoma

____|____|____ Hay Fever

____|____|____ Headaches

____|____|____ Heart Attack

____|____|____ Heart Murmur

____|____|____ Heart Surgery

____|____|____ Hemophilia

____|____|____ Hepatitis ____ Type

____|____|____ Herpes/Fever Blisters

____|____|____ High Blood Pressure

____|____|____ HIV+/AIDS

____|____|____ Hospitalization for any reason

____|____|____ Jaw Pain/TMJ

____|____|____ Kidney Problems

____|____|____ Liver Disease

____|____|____ Low Back/Hips/Leg Pain

____|____|____ Low Blood Pressure

____|____|____ Lupus

____|____|____ Mitral Valve Prolapse

____|____|____ Neck/Shoulder/Arm Pain

____|____|____ Nervous Disorders

Y | I | N

____|____|____ Pacemaker/ICD

____|____|____ Psychiatric Care

____|____|____ Radiation Treatment

____|____|____ Hepatitis

____|____|____ Rashes

____|____|____ Rheumatic/Scarlet Fever

____|____|____ Seizures

____|____|____ Sexually Transmitted Disease

____|____|____ Shingles

____|____|____ Sickle Cell Disease

____|____|____ Sinus Problems

____|____|____ Spasms/Cramps

____|____|____ Sprains/Broken Bones

____|____|____ Stomach Problems

____|____|____ Stroke

____|____|____ Tendonitis

____|____|____ Thyroid Problems

____|____|____ Tuberculosis (TB)

____|____|____ Tumors

____|____|____ Ulcers

____|____|____ Other

Please list: _____

Initials _____

Medical History Continued...

Are you allergic to any of the following? If so, please circle.

Aspirin	Latex	Sulfites
Codeine	Penicillin	Any Metals
Dental Anesthetics	Tetracycline	Erythromycin

Have you ever taken any of the following?

<input type="checkbox"/> Phen-Fen	<input type="checkbox"/> Cortico-Steroids
<input type="checkbox"/> Vioxx	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Fosamax	

Please list any other drugs or items that you are allergic to:

Do you consider your current overall physical health to be: Good Fair Poor

Are you currently under the active care of a physician or do you have any present health issues? Yes No

If yes, please explain: _____

Do you need to be pre-medicated with antibiotics for any heart or other medical conditions prior to dental treatment? Yes No

Are you taking any prescription or over-the-counter medications? (including Ibuprofen, diet supplements, etc.) Yes No

Please list each one: _____

Are you pregnant or nursing? Yes No

If pregnant, which trimester? 1st 2nd 3rd

What is your due date? _____

INFORMATION ABOUT YOUR DENTAL TREATMENT...

The purpose of the following sections are to inform you of the dental procedures that we routinely perform here, to emphasize the importance of your role and cooperation in achieving a high level of oral health and beauty and to point out the potential risks and inconveniences that may be encountered before, during and after treatment.

Your dental treatment may involve one or a combination of the following procedures that are summarized below.

DESCRIPTIONS OF CERTAIN DENTAL PROCEDURES...

Examination & Hygiene Cleanings: The initial examination and hygienic cleaning are intended in part to evaluate and make recommendations regarding the health and appearance of your teeth and gums. The dental exam, hygienic cleaning and any basic restorative (i.e. fillings) or gingival therapy may involve the touching, scaling or periodontal probing of your teeth and oral tissues. Other or subsequent hygienic procedures (periodontal scaling, root planing, etc.) may be indicated and performed as well depending on your condition. These procedures are designed to remove plaque and calculus from your teeth and help maintain or restore the health of your gums.

Fillings or Bonding are terms that are commonly used to refer to the placement of composite resins or other appropriate materials in cavities or on teeth. Bonding can also be used to fix broken or chipped tooth surfaces. It can also be used to close spaces between teeth. We do not place amalgam (sometimes called silver or mercury fillings) in our office because we believe that there are more desirable restorative materials such as tooth colored composites and porcelain. Although some people have had amalgam fillings for many years, we can remove the amalgam fillings as they begin to break down, or we can remove them per your request and replace them with a more desirable restorative material. We want to make you aware that amalgam suppliers report that after placement or removal of amalgam fillings, there can be a slight but measurable increase in mercury in your blood and/or urine.

An **Onlay** may be the recommended treatment when teeth have had decay or are broken down but retain enough healthy tooth structure to allow for restoration of certain voids in the tooth structure. The tooth is prepared much like a normal filling. The restoration can be fabricated out of composite resin or porcelain and then bonded into the void. This procedure is used when the void is too large to be filled by regular filling material.

Crowns, Veneers and other porcelain restorations and enhancements are designed to be life-like looking tooth restorations made out of porcelain or porcelain plus other materials. A crown usually covers the entire tooth structure (although there are 3/4 crowns and other variations that do not cover the entire tooth structure). Typically, more tooth structure is removed to prepare for a crown placement than a veneer (which may entail zero, minimal or significant tooth reduction, depending on the circumstances). Crowns may be recommended for teeth requiring additional support due to the loss of healthy tooth structure. Veneers primarily cover the front of the teeth, although some varieties have porcelain on the backside of the teeth. While the porcelain enhancements are being fabricated, you will have temporary crowns or veneers, which are not intended to be permanent and are easier to remove or pop off.

A **Bridge** is a replacement made for missing teeth. It is usually composed of porcelain or porcelain fused to a harder substance which is bonded to adjacent teeth. These abutment teeth may require some reduction or crowning in order to support the teeth being replaced.

Root Canal Therapy can be indicated anytime a tooth receives trauma, decay, dental work performed on it, or for no reason at all. In general, the more trauma or amount of work, the higher the risk a root canal will be needed. This therapy consists of removing the damaged or infected nerve in the tooth and replacing it with a sterile material. If there are existing restorations in place, this procedure can many times be performed without destroying the restoration, although destruction of the existing restoration is a risk as well. Studio B Smiles attempts to predict and notify you in advance of the likelihood of root canal therapy depending on your procedure; however, all people are different and the human body can react in a myriad of unpredictable ways. Thus, it is impossible to always make accurate predictions of this sort in the vast majority of cases. Therefore, regardless of cause, should you require subsequent root canal therapy or restorative work (whether obtained here or at another office), which has not been paid for as a part of your treatment plan, you agree to be responsible for these costs. Even in the best case scenario, under ideal conditions, 5% of all root canal treated teeth will not last the duration of your life. Any treatment needed above and beyond root canal therapy (i.e. tooth extraction, implant or bridge), is also your responsibility.

DESCRIPTIONS OF DENTAL PROCEDURES CONT...

Local Anesthetic of various types may be used to block certain nerve impulses and numb the oral tissues before certain dental procedures. These are administered by injections to prepare for a number of both simple and complex periodontal and dental procedures. It is your responsibility to inform our office if you have ever had an adverse reaction or allergy to anesthetic.

Nitrous Oxide is sometimes called "laughing gas" and can result in feelings of relaxation, a reduced sense of fear or anxiety, increased tolerance to pain or discomfort, an altered perception of time, a tingling sensation especially in the fingers and toes, giddiness or light headedness, nausea, vomiting, incontinence, hallucinations or dreams. While the use of nitrous oxide is safe and effective for most people, it is not recommended for use on all patients. If you have any of the following conditions, you may not be a good candidate for nitrous oxide: chronic obstructive pulmonary disease (emphysema), upper respiratory or throat infections, any acute respiratory conditions such as cold, flu, or sinus infection, claustrophobia, compulsive personality disorder, if you are taking any psychiatric mood altering drug, bowel obstructions, middle ear disturbances, or pregnancy. Please notify Dr. Badolato if you have any of these conditions, and we will discuss other options that may be available.

Whitening is performed by applying a peroxide based gel to the teeth. This can either be done in our office with an accelerated method or through a take home system. The peroxide reacts with the tooth structure to safely whiten the teeth. Porcelain or composite restorations will not whiten with peroxide whitening systems.

Tooth Contouring is the reshaping of existing tooth structure by removing small amounts of enamel usually around the edges. We give particular attention to the edges of the upper and lower front six teeth which may be reshaped to create a more aesthetic result.

Gum Contouring is the reshaping of the gum tissue which is often done to give a more symmetrical appearance. This is usually done with a laser. In the hands of an experienced cosmetic dentist, it is a relatively simple but dramatic procedure. Most patients report that they feel a burning sensation similar to the feeling you would have if you ate a piece of pizza that was too hot for a couple of days after the procedure.

Implants are a great replacement option for missing teeth. A dental implant is a piece of titanium shaped like a tooth's root. The titanium is implanted into the area of the missing tooth in a simple outpatient procedure. The implant has threads that engage the jaw bone and hold it in place. In some cases, crowns can be immediately placed onto the implant due to the strength of the underlying bone. In other cases, where bone may be lost or of poor quality, the implant will actually integrate with the jaw as bone cells grow around and secure the implant in place. Once the implant is secure, it will need to be restored with an abutment (which screws into the implant and mimics your natural tooth structure) and a crown.

ADDITIONAL TREATMENT INFORMATION...**Specific Results Are Not Guaranteed**

The dental procedures described above have a very high degree of success at Studio B Smiles. The human body, however, reacts differently to different dental treatments depending on a wide variety of factors. Each individual is different and the exact result for each specific case is difficult if not impossible to guarantee. Thus, as with any branch of medicine or dentistry, our treatment carries with it no guarantee of specific results. There are many variables that affect how long restorations, whitening, or other dental treatments can be expected to last and how the teeth and gums will react, including but not limited to, general health, maintenance of good oral hygiene, regular dental checkups, etc. No matter how well done, chipping, breaking, loosening of dental work can occur. No guarantees can be made or assumed regarding treatments. Please talk with Dr. Badolato if you want to know the average lifespan of the dental work you are considering.

Alternative Treatments & Providers

There is usually more than one way of doing things and there may be alternative treatments to what Dr. Badolato recommends for you which may include, but are not limited to, one or more various combinations of veneers, crowns, bonding, onlays, whitening, contouring of teeth and/or gums, bridges, dentures, extractions, root canal therapy, fillings, orthodontics, non-surgical therapy, surgical curettage or cleaning, implant placement and/or restoration as well as a variety of other dental treatments. All dental treatments have risks, so please make sure you have had an opportunity to ask about these alternatives and have them explained to your satisfaction. In addition, the dental treatments in our office are typically, but not always, performed by a general dentist. Another option is for you to have some of the above treatments completed by one or more specialists (i.e. orthodontist, endodontist, oral surgeon, periodontist, etc.). After hearing general descriptions of alternative treatments, if you would like a referral to any dental specialist, please let us know and we will be happy to provide a referral.

Non-Treatment Option

One option is to have no treatment performed. This alternative may entail a number of actual or potential risks, each of which are difficult or impossible to quantify or predict for specific cases. Some of the risks of non-treatment include, but are not limited to, exacerbation of any existing symptoms; deterioration of aesthetics or function of your teeth; improper biting; tooth, head and/or neck pain; fracturing of teeth; discoloration or staining of your teeth; rotation or movement of teeth; TMJ complications; additional wear of your teeth to the point that they are no longer a candidates for reconstruction; loss of teeth; bite problems; poor chewing; loosening of teeth; need for dentures; gum recession; bad breath; inability to perform adequate oral hygiene; abscesses or infection; pain; tooth sensitivity; tooth movements; worsening periodontal condition; deeper pocketing; and other oral health problems.

Risks and Inconveniences

Inherent in your treatment plan, as well as with many similar or other dental procedures, are certain actual and potential risks and inconveniences which vary based on individual circumstances and variations in teeth and gums. These risks and inconveniences may last for a short while or an indefinite length of time.

General Dental Inconveniences & Risks include, but are not limited to, bruising; discoloration; recession; abscesses; the need to repeat all or part of the procedures for known or unknown reasons; exposure of crown margins or edges; lisp; speech impediments or speaking difficulties; infections; viruses; stretching of the mouth resulting in cracked corners; tooth mobility; oral surgery; food impaction; root staining; oral opening restrictions; tissue sloughing; the onset of or continued periodontal disease; root canal therapy; numbness of lip, chin, gums, and or tongue; dental neuropathy; gagging; joint pain/disorder; accidental nicks or cuts from dental instruments or needle sticks to the body; chipping, breaking of fillings in other teeth; loosening of the temporary or permanent restorations; temporomandibular joint (jaw joint) problems; nausea; bone or tooth fracture; adverse reaction to drugs, medications, and/or anesthetics (including nitrous oxide); dyspepsia; gum hemorrhage; mouth ulceration; tongue edemas; tooth disorder; varying psychological reactions; dental work that does not match the color of the surrounding teeth or dental work; trapping for saliva or food; loss of surface shine from restorations, ledges; or local tissue necrosis.

The more common risks include, but are not limited to, swelling; tooth sensitivity; bleeding; gum irritation; gum, bone, or teeth inflammation; stiffness of facial muscles; temporary numbness or tingling in the lip, tongue, teeth, gums, chin, cheek and/or jaw area; changes in ...the occlusion; need for a night guard; permanent reduction of tooth structure; a need for you to modify the frequency or methodology of your home hygiene care (i.e. brushing and flossing to adequately go around corners, edges, etc.); or wearing temporary teeth for an undefined period of time as well as the general dental inconvenience and risks set forth above.

The more remote general dental risks include, but are not limited to, loss of teeth; implant rejections; permanent numbness or tingling in the lip, tongue, teeth, gums, chin, cheek and/or jaw area; severe pain; permanent or temporary injuries to the nerves of the tongue, jaw, chin and lips, including lingual nerve injury (tongue) and inferior alveolar nerve damage (lips, chin and jaw), permanent or temporary structural injuries to the tongue, jaw, chin, or lips; parasthesia; sutures; accidentally swallowing or aspirating on dental restorations, materials, dental tools; changes in facial appearance; referred pain to the ear, neck, jaw, head; allergic reaction; delayed healing; sinus complications; constipation; diarrhea; vomiting; aspiration of vomit; systemic toxicity; respiratory distress; heart failure; or death. There may be additional unknown or unlisted risks at this time, but that could manifest at a later time.

Additional information you should know prior to starting dental work: You understand that your condition may be the same, better or worse after treatment. If previously placed dental restorations are in place on teeth, your treatment may entail additional alteration of tooth structure to properly prepare these teeth for new restorations; and/or other unknown or unspecified problems or risks, which Studio B Smiles may or may not have encountered, and which are difficult or impossible to predict or quantify in advance.

YOUR OBLIGATIONS...

Cooperation

Successful dental treatment is a team effort involving you as the patient, the doctor and our team. Without cooperation, successful treatment planning, achieving optimal results, and maintaining the treatment results are difficult or impossible and the results may be disappointing to everyone.

Scheduled Appointments

In order to serve our patients better, we strive to operate a professional, efficient dental practice. We attempt to reserve appropriate blocks of time for each of our patients so that the procedures may be completed with close attention to detail and with as few interruptions as possible. Missed appointments have a negative effect on our ability to maintain the level of service you and other patients deserve. While we are aware that circumstances may arise which interfere with set appointments, we require at least one business day notice to cancel or reschedule an appointment. Failure to provide this notice may result in a missed appointment fee which is not intended as a penalty, but as a reasonable estimate of the time and expense incurred by the Practice in attempting to fill such a cancellation or loss of deposit.

Financial Obligations

You have full responsibility for payment of the dental services that you or your dependents receive at Studio B Smiles. Fees are due and payable in full at or before the time services are rendered. A 1.5% finance charge (18% annually) will be added to any balance over 30 days past due. In the event of your failure to pay amounts owed when due, you agree to pay for collection costs and reasonable attorneys fees as may be incurred for collection.

Providing Timely Information & Authorization for Signature on File

To process insurance documents, claims and related matters, you authorize Studio B Smiles to affix your signature and name to claims or documents related to insurance, claims or health benefits due to you. A photocopy of this form will act as an original. Studio B Smiles may disclose information provided by me or obtained during the course of my treatment for treatment, payment, or healthcare operations, including disclosure to laboratories, other dental offices, or professionals involved in my care, and to my insurance providers. As part of your treatment, you authorize Studio B Smiles to take radiographs (x-rays), study models, provide injections, take photographs, and give or perform any other diagnostic tests and aids deemed appropriate by Studio B Smiles to evaluate your condition and to generate recommendations, for professional or educational purposes and for any other use as contemplated or set forth in Studio B Smiles current Notice of Privacy Policies, which is incorporated herein by reference.

Maintenance Obligations

For successful treatment results and to lessen the risks of complication, you agree to comply with your individualized maintenance program and keep excellent home oral hygiene. It is typical to need follow-up visits for occlusal or other adjustments after treatment. You agree to notify Studio B Smiles at the soonest possible moment in the event that you experience pain, discomfort or any other problem that you believe may be related to treatment in our office. Nothing in this form extends the applicable statutes of repose or limitations for dental services. You agree to keep your follow-up appointments and to follow recommended treatments as well as follow other precautions and recommendations that may be provided as part of your pre-op or post-operative instructions.

Your Insurance

At Studio B Smiles, we realize how important insurance benefits are. We ask that **you** carefully review your policy and/or contact your insurance carrier, so that **you** are aware of benefits, frequencies, limitations, and/or restrictions. **Please be informed YOUR dental insurance is a contract between YOU and YOUR insurance company. Our role is to simply assist you with filing your claims.** While we will obtain a summary of benefits from your insurance, it is up to you to know the frequencies, limitations and/or restrictions of your plan. Please note that Dr. Badolato strives to provide you with the highest quality of care for you and your family regardless of insurance frequencies, limitations and/or restrictions. Please be aware that your insurance may have a yearly allowance (maximum), and anything over that amount will be your responsibility. If you have two insurance policies, please be aware of both policies – not all secondary policies will cover remaining portions. Your insurance mails a copy of an Explanation of Benefits (EOBs) to you. Please pay attention to these statements. Please provide us with a copy of your insurance card at your first visit or any time you have changes in your dental insurance coverage. It is your responsibility to provide us with any changes in your insurance. If any

YOUR CONSENT...

The information I have provided on this form is accurate and complete to the best of my knowledge, information, and belief. I will notify Studio B Smiles at the soonest practical moment of any changes in the information I have provided. In consideration of being accepted as a patient of Studio B Smiles, I agree to abide by the terms and conditions of this Patient Application & Practice Agreement.

By signing below, I acknowledge that I have been given time to read and have completely read (or had read to me) the preceding information in this document and I acknowledge that Studio B Smiles has explained to me in general terms the descriptions of certain anticipated dental procedures and treatments, alternatives (including non-treatment), and the risks and inconveniences of treatments. By proceeding with each and every step in my treatment, I acknowledge that: (1) I have been given the opportunity to ask any questions and any questions have been answered or explained to my satisfaction prior to performance of any treatment or procedure, and (2) I authorize Studio B Smiles to perform any and all such recommended forms of treatment, medication and therapy that may be necessary or advised. I understand that during the course of the procedures described above, it may be necessary, appropriate, or Studio B Smiles recommendation to perform additional procedures which are unforeseen or not known to be necessary, appropriate or recommended at the time this consent is given. I consent to and authorize the performance or such additional procedures as they deem necessary, appropriate, or recommended under the circumstances.

Signature _____ Date _____

Patient’s Authorized Representative—(If patient is under 18 years of age or you are consenting to the care of another):

I have the legal authority to sign this consent on behalf of:

Patient Name: _____

Your Relationship to Patient: _____

Signature _____ Date _____

STUDIO B SMILES - NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by 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 May 8, 2013, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. We will post a copy of our notice in our office and on our website www.dentalworks.com. The effective date of the Notice is provided above.

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 the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

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, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

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

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: 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, and healthcare operations, and certain other activities for the last 6 years, but not before May 8, 2007. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 8952 E Desert Cove Ave., Ste. 108, Scottsdale, AZ 85260

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 8952 E Desert Cove Ave., Ste. 108, Scottsdale, AZ 85260. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 8952 E Desert Cove Ave., Ste. 108, Scottsdale, AZ 85260

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer, 8952 E Desert Cove Ave., Ste. 108, Scottsdale, AZ 85260. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We 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.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
8952 E Desert Cove Ave., Ste. 108
Scottsdale, AZ 85260
Telephone: 480-860-0092

