Welcome

Name:______________________________ Nickname:______________ Male / Female Birthday:__________ Age:_____

Address:____ Zip:__________ Home Phone (   )__________

Marital Status:________________ Driver's Lic#:_______________ State:_____ Exp:______ Cell Phone (   )__________

Employer:_____________________________________ Occupation:____________________ Work Phone (   )__________

Social Security#:______________________________ E-mail Address:____

Emergency Contact:____ Phone (   )__________

Nearest Relative not living with you:____ Phone (   )__________

Who can we thank for referring you?____

Parent/Spouse Information

Name:____ Male / Female Birthday:__________ Age:_____

Address:____ Zip:__________ Phone (   )__________

Employer:___________________________________ Occupation:________________ Social Security#:________________

Insurance Information

Primary Insurance Company:___________________________ ID#:_______________ Group/Policy#:________________

Employer / Self:___________________ Address:______________________________ Zip:________ Phone (   )__________

Subscriber's Name:________________________________ Birthday:___________ Social Security#:____________________

Secondary Insurance Company:________________________ ID#:_______________ Group/Policy#:________________

Employer / Self:___________________ Address:______________________________ Zip:________ Phone (   )__________

Subscriber's Name:________________________________ Birthday:___________ Social Security#:____________________

Other Information

May we discuss/disclose personal/health Information with any family member?

Name:____ Y / N Name:_____________________________________ Y / N

Name:____ Y / N Name:_____________________________________ Y / N

Name:____ Y / N Name:_____________________________________ Y / N

I acknowledge responsibility and accuracy of the information on this form:

Signature:_____________________________________ Date:_____________________

Time 9:37 AM

Pacific Coast Dentistry

Date 2/16/2016

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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

Question	Answer	
Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you 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	

Women: Are you...

☐ Pregnant/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?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

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:__________

Dental History

Previous Dentist______________________________

Last x-rays taken______________________________

Last cleaning______________________________

Major dental problem and/or reason for coming______________________________

____

Do you <u>or</u> have you ever had:

YES NO Bad Breath
YES NO Bleeding Gums
YES NO Burning Mouth
YES NO Clenching
YES NO Dry Mouth
YES NO Grinding

YES NO Braces
YES NO Gum Treatment or Surgery
YES NO Injury to head or neck
YES NO Loose Teeth
YES NO Jaw Pain or Tiredness
YES NO Mouthguard

Are you able to sit for a three hour dental appointment? ______________________________

Are you active in sports? ______________________________

Is there anything about the appearance of your smile you would like to change? ____________________

Did you ever avoid a dental appointment because you were frightened?____________________

Have you ever been dissatisfied with dental treatment? Please describe. ____________________

____

PLEASE DO NOT WRITE BELOW THIS LINE

ASA Class: ____________________Dr. Signature:______________________________Date:__________

Doctor's notes:____

____

____

Patient Acknowledgment of receipt of Dental Materials Fact Sheet

I, ____, acknowledge that I have received and reviewed from Pacific Coast Dentistry, a copy of the Dental Materials Fact Sheet dated October 2001.

____ ______________________________

Patient Signature Date

The following document is the Dental Board California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Materials Fact Sheet; and it's linkage to the DCA site does not constitute an endorsement of the content of this document.

The Dental Board of California
Dental Materials Fact Sheet

Adopted by the board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." "A Glossary of Terms," is also attached to assist the reader in understanding the term used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of material from which the restoration was made.

The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet, and chewing habits.

Acknowledgement of privacy policies and consent for use and disclosure of personal health information

This form authorizes us to use and disclose your protected health (PHI) for the purposed of healthcare operation, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

I, ____, have read your Notice of Privacy Policies and I consent your use of my PHI for the purposed of healthcare operations, treatment and payment activities.

If this consent is signed by personal representative on behalf of the patient, complete the following:
Personal Representative's Name:________________________
Relationship to Patient:________________________________

Office Financial Policy

<u>We require payment at the time of service.</u> We expect you to cover the cost of your dental treatment as service is rendered. For your convenience we accept Visa, MasterCard, Discover, American Express, Cash, or Personal check as payment. Outside financing is available on approved credit.

- We send out monthly statements directly from our office. Full payment is due unless the balance is expected to be paid by insurance.
- Those patients with insurance are expected to pay their estimated amount at the time of their appointment. You are responsible for payment of your account whether or not your insurance pays their estimated portion.
- We will assist you in planning your treatment around your financial considerations, and will always work to help you understand your insurance benefits. We require updated benefit information at all times in order to accurately estimate payment due.
- Those with dental insurance authorize payment of the dental benefits otherwise payable to you directly to Pacific Coast Dentistry and the release of any information relating to insurance claims.

Appointment Reservation Agreement

Here at Pacific Coast Dentistry we view you as an internal part of your oral health care team and feel that to best maintain your health, we ask that you follow these guidelines. Because time is valuable, we ask you respect your reserved appointment time with us.

We agree to be respectful of your time when you are in our office and in order for us to keep our costs low it is important that our patients agree to committing to their reserved times.

As a courtesy we send reminders three weeks prior to your reservation. We ask that your contact us within a week of receiving this reminder should you need to make any changes.

Within four days of your reserved appointment we send a final reminder and we request you confirm with us that you are aware and we will be seeing you on time.

Your oral health is our priority, missed and/or delayed treatment may increase your risk to more extensive care in the long run.

If patients fail to respect this agreement, we reserve the right to require a non-refundable deposit to hold future reservations.

Thank you for being such a willing part of your oral health care. We look forward to providing you and your family quality and compassionate dental care.

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________________

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 now? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No **DO YOU TAKE ANY MEDICATIONS FOR OSTEOPOROSIS? YES NO**
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ______________________

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________________

Comments: ______________________

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 ______________________ DATE ______________

Pacific Coast Dentistry

Authorization for Treatment and Diagnosis
Release of Dental Records

I the undersigned do hereby authorize and consent to x-rays, examination, anesthetic, dental and surgical diagnostic procedures and/or treatment considered necessary.

I understand that if photographs, slides, and/or videos are taken, they will be used as a record of my care, and may be used for educational purposes and lectures, demonstrations, and professional publications.

I authorize Pacific Coast Dentistry to release any information acquired in the course of the examination.

____

Signature of Patient/Parent/Guardian — Date

____

Witness — Date

____

Dr. Signature — Date

Acknowledgement of Receipt of Notice of Privacy Policies

I, ____, have received a copy of

Pacific Coast Dentistry's Notice of Privacy Policies.

____

Name (print)

______________________________ ________________

Signature Date

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact:

Office Administrator, You may reach (*him/her*) by telephone @ (805) 226-8126

Patient's Consent

Name: ________________________

Address: ________________________

City: ________________________ State: ______ Zip: ________

Telephone: ( ) ________________ E-mail: ____________________

Patient #: ________________________ Social Security #: ______ ____ ______

I, ________________________________, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

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

Personal Representative's Name: ______________________________

Relationship to Patient: __________________________________

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed

PACIFIC COAST DENTISTRY

WELCOME

Patient Information

Name: ______________________ M / F Birthdate: __________ Age: ____ Married / Single

Address: ______________________ Zip ______________ Phone ( ) ____________

Cell ( ) ____________

Employer: ______________________ Occupation ____________ Phone ( ) ____________

Social Security # ______________________ Drivers Lic# ____________ State ________ Exp. ________

Emergency Contact: ______________________ Phone ( ) ____________

Nearest Relative not living with you: ______________________ Phone ( ) ____________

Who can we thank for referring you? ______________________

Parent/Spouse Information

Name ______________________ Male/Female Birthdate: ____________ Age: ________

Address: ______________________ Phone ( ) ____________

Employer: ______________________ Occupation: ________ Soc Sec # ____________

Insurance Information

Insurance Company: ______________________ Group/Policy # ____________

Address: ______________________ Zip ____________ Phone( ) ____________

Name on Policy: ______________________ DOB ________ Soc. Sec# ____________

Secondary Ins. Co.: ______________________ Group/Policy ____________

Address: ______________________ Zip ____________ Phone( ) ____________

Name on Policy: ______________________ DOB ________ Soc Sec# ____________

Other Information

List names and relationship of persons in immediate family.

Name: ______________________ ______________________

Name: ______________________ ______________________

Name: ______________________ ______________________

I acknowledge responsibility and accurancy of the information on this form

Signature: ______________________ Date: ____________

Dental History

Previous Dentist:____

Last x-rays: ____

Last Cleaning: ____

Major dental problem or reason for coming:____________________________

Do you have or had:

Yes No Bad breath
Yes No Bleeding Gums
Yes No Burning mouth
Yes No Clenching
Yes No Dry mouth
Yes No Grinding

Yes No Braces
Yes No Gum treatment or surgery
Yes No Injury to head or neck
Yes No Loose teeth
Yes No Jaw pain or tiredness
Yes No Mouthguard

Are you available to sit for a three hour dental appointment?____________________

Are you active in sports?____

Is there anything about the appearance of your smile you would like to change?____________

Did you ever avoid a dental appointment because you were frightened?________________

Have you ever been dissatisfied with dental treatment? Please describe________________

____

Do not write below this line

ASA Class:__________ Dr. Signature____________________________ Date__________

Doctor's Notes:____

OFFICE FINANCIAL POLICY

We require payment at the time of service. We expect you to cover the cost of your dental treatment as service is rendered. For your convenience we accept Visa, Master Card, cash, or personal check as payment. Outside financing is available on approved credit.

- We send out monthly statements directly from our office. Full payment is due unless the balance is expected to be paid by insurance.
- Those patients with insurance are expected to pay their estimated amount at the time of their appointment. You are responsible for payment of your account whether or not your insurance pays their estimated portion.
- We will assist you in planning your treatment around your financial considerations, and will always work to help you understand your insurance benefits. We require updated benefit information at all times in order to accurately estimate payment due.
- Those with dental insurance authorize payment of the dental benefits otherwise payable to you directly to Pacific Coast Dentistry and the release of any information relating to insurance claims.

______________________________ ________________

Signature Date

A photo copy of this document may act as an original

TRUTH IN LENDING

EXPLANATION OF LATE CHARGES AND FINANCE CHARGES

Late charge: If your minimum payment is not received by the due date, you may be assessed a late payment charge. The amount of the late charge is that maximum amount authorized under the laws of the state of your domicile. In most states, the late charge will be $5.00 or 5% of the past due minimum payment, which ever is greater, with a maximum of $20.00.
Finance charge: A finance charge is imposed on those charges not paid within the time period shown below on the front of your billing statement. The finance charge is a periodic rate of 1.25% per month and is computed by multiplying the balance on which the finance charge is computed by the periodic rate shown above. There is a $1.00 minimum finance charge.

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think that you have been billed incorrectly, or if you need more information about the transaction on your bill, write to us on a separate sheet at 143 Niblick Rd., Paso Robles, CA 93446. We must hear from you no later than 60 days after we have sent you the first bill on which the problem or error occurred. You may phone us at (805) 226-8126 but doing so will not preserve the rights. In your letter please include the following information

- Your name and account number
- The dollar amount of the suspected error
- Describe the error and explain why you believe there is an error

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days we must either correct the error, or explain why we believe the error was correct.
- After we receive your letter we can not try to collect any amount you question or report you as delinquent. We can continue to bill you for the amount in question including finance charges and we can apply any unpaid amount against your credit limit. You do not have to pay the portion of you bill that we are investigating, but you are obligated to pay the portion that is not in question.
- If we find that we make a mistake on your bill, you will not have to pay any finance charges related to that questioned amount. If we did not make a mistake, you will have to pay any finance charges and make up for the missed payments on the questioned amount. We will send you a statement of the amount you owe and the date it is due.
- If you fail to pay the amount due we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell any one we report you to that you have a question about your bill. We must tell you the name of any one we have reported you to. Once the problem is settled between us, we must notify any one we reported you to that the matter is settled.
- If we do not follow these rules we can not collect the first $50.00 of the questioned amount, even if your bill was correct
- Your continued use of this account constitutes your acceptance of the above stated conditions.

Signature______________________________________ Date______________________________

Patient Acknowledgment of receipt of Dental Materials Fact Sheet

I, ____________________, acknowledge that I have received from Pacific Coast Dentistry, a copy of the Dental Materials Fact Sheet dated October 2001.

____

Patient Signature Date

The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Materials Fact Sheet; and it's linkage to the DCA Web site does not constitute an endorsement of the content of this document.

The Dental Board of California
Dental Materials Fact Sheet

Adopted by the board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." "A Glossary of Terms," is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of material from which the restoration was made.

The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet, and chewing habits.