



210 S. Grand Avenue Suite 420  
Glendora, CA 91741  
(626) 963-3322

## PATIENT REGISTRATION

PATIENT FIRST NAME, LAST NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (Mobile) \_\_\_\_\_ (Work) \_\_\_\_\_ (Home) \_\_\_\_\_  
Email \_\_\_\_\_  
How did you hear about our practice? \_\_\_\_\_

### INSURANCE INFORMATION (Please Circle One: PPO DHMO DENTI-CAL NO INSURANCE)

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

\*\*\*Please present your insurance card to be photocopied for our records.

### RESPONSIBLE PARTY (If minor)

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Initial: \_\_\_\_\_  
Address (If different) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_  
Email: \_\_\_\_\_

### EMERGENCY CONTACT

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Initial: \_\_\_\_\_  
Telephone (  Mobile     Work     Home ) \_\_\_\_\_

### AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

**ELECTRONIC COMMUNICATIONS.** I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text to 6269633322.

I attest to the accuracy of the information on this page.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Responsible Party, if under 18)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)**

1. Yes / No Is your general health good?  
If NO, explain: \_\_\_\_\_
2. Yes / No Has there been a change in your health within the last year?  
If YES, explain: \_\_\_\_\_
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?  
If YES, explain: \_\_\_\_\_
4. Yes / No Are you being treated by a physician now? If YES, explain: \_\_\_\_\_  
Date of last medical exam? \_\_\_\_\_ Reason for exam: \_\_\_\_\_
5. Yes / No Have you had problems with prior dental treatment?  
If YES, explain: \_\_\_\_\_  
Date of last dental exam: \_\_\_\_\_ Name of last treating dentist: \_\_\_\_\_
6. Yes / No Are you in pain now?  
If YES, explain: \_\_\_\_\_

**II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING WITHIN THE LAST 3 MONTHS? (Please circle Yes or No for each)**

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Other: \_\_\_\_\_

**III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)**

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexual transmitted disease
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other: \_\_\_\_\_

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)**

Yes / No Aspirin	Yes / No Valium or sedatives	Yes / No Codeine or other opioids
Yes / No Ibuprofen	Yes / No Latex	Yes / No Food
Yes / No Penicillin or <u>other</u> antibiotics	Yes / No Local Anesthetic	
Yes / No Nitrous oxide	Yes / No Metal	

Others:

**V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?**

(Please circle Yes or No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin
Yes / No Anti-Depressants	Yes / No Herbal supplements	
Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: _____		

Please list all prescription medications: \_\_\_\_\_

**VI. WOMEN ONLY (Please circle Yes or No for each)**

Yes / No Are you or could you be pregnant? If YES, what month? \_\_\_\_\_  
Yes / No Are you nursing?  
Yes / No Are you taking birth control pills?

**VII. ALL PATIENTS (Please circle Yes or No for each)**

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?  
If YES, please explain: \_\_\_\_\_

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: \_\_\_\_\_

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

*The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.*

*I authorize the dentist to contact my physician.*

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Whom would you like us to contact in case of an emergency?):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

Signature of Patient (Parent or Guardian)

Date

Signature of Dentist

Date

6 mo. Signature of Patient (Parent or Guardian)

Date

Signature of Dentist

Date

## **Patient Responsibility & Consent for Communication**

\_\_\_\_\_  
Initials \_\_\_\_\_ **Financial Responsibility:** I request that all benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the service provider. I understand that I am responsible for all charges for services whether or not paid by insurance. I authorize the service provider to disclose all information necessary to verify my insurance eligibility and secure the payment of benefits.

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

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



## ARBITRATION AGREEMENT

Patient Chart No. \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must Be Arbitrated:** It is the intention and agreement of the parties that this arbitration agreement shall cover all claims or controversies relating to the matters described in Article 1 above, except claims within the jurisdiction of the Small Claims Court, whether in tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described in Article 1 may arise out of or in any way relate to treatment or services provided or not provided by Foothill Family Dental Group, ("FFDG") or any employee or agent or providers of FFDG, including any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. The undersigned understands and agrees that if the undersigned signs this Contract on behalf of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. The reference to FFDG includes the corporation, and its employees, agents and providers. Filing any action in any court by FFDG to collect any fee from Patient shall not waive the right to compel arbitration of any claim described in Article 1. However, following the assertion of any claim against FFDG, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by the same arbitration.

**Article 3: Procedures and Applicable Law:** Patient shall initiate arbitration by serving a Demand for Arbitration on FFDG and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: Foothill Family Dental Group, 210 S. Grand Avenue Suite #420, Glendora, CA 91741. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient and his/her attorney. Patient and FFDG agree that any arbitration hereunder shall be conducted by a single, neutral arbitrator selected by the parties and shall be resolved using the rules of the American Arbitration Association. (Arbitration, however, shall not be conducted by the American Arbitration Association.) Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Civil Code §§ 3333.1 and 3333.2, Code of Civil Procedure §§ 340.5, 667.7, 1281-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1- 9), as in effect from time to time.

**Article 4: Retroactive Effect:** Patient intends this Contract to cover services rendered by FFDG not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

**Article 5: Severability:** If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

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

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

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Signature of Patient/Responsible Party

Print Name

Date Signed

### FFDG'S AGREEMENT TO ARBITRATE

In consideration of the foregoing agreements under this Contract, FFDG likewise agrees to be bound by the terms set forth in this Contract and to the rules specified in Article 3 above.

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Prepared By FFDG Employee

Print Name

Date Signed

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

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

- Dental Materials Fact Sheet
- Notice of Privacy Practice

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Signature of Patient/Responsible Party

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Print Name

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Date Signed

### For FFDG's Dental USE Only

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

■ Individual refused to sign	■ Communications barriers prohibited obtaining the acknowledgement	■ An emergency situation prevented us from obtaining acknowledgement
■ Other (please specify): _____		





# Foothill Family Dental Group

## Dental Need Survey

**YES    NO**

Do you like to smile wide enough to show your teeth? ( ) ( )

Are you happy with the way your teeth look? ( ) ( )

Do you like the look of your crowns and fillings? ( ) ( )

Are your teeth too long? Too short? ( ) ( )

Are you missing teeth? ( ) ( )

If you could change one thing about your smile, what would it be?

**I would like to know about these options available to me for maximizing my comfort and my experience during my visit. (Check all that apply)**

## Patient Education Materials

## Nitrous Oxide      Sedative Medications

**Are you concerned about the following (Check all that apply):**

Existing discomfort in teeth or gums  Brightening your smile

Replacing old silver fillings    Improving the appearance of your smile

Bleeding gums while brushing/flossing  Prevention of cavities

Mouth odor    Other \_\_\_\_\_



**Foothill Family  
Dental Group**

### **Patient Cancellation Policy**

Your appointment is a time that has been set aside exclusively for you with our office at Foothill Family Dental Group.

Appointments are in high demand and our doctors have limited availability. Tardiness, last minute cancellations, and/or “no-shows” may be subject to not being able to reserve time in the future as we may not be able to reschedule you in a timely manner.

We will attempt to contact you for confirmation of your appointment or to schedule your treatment. If there is no response after three attempts, we consider this as you not wanting to keep your appointment.

We understand that your time is very valuable to you, and in effort to respect your time and that of other patients, we require a **TWO BUSINESS DAY** notice to change or cancel your appointment.

Last minute cancellations and no shows May be subject to a **broken appointment or cancellation fee.**

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Patient Name

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Patient Signature

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Date

# Dental Materials Fact Sheet

## **What About the Safety of Filling Materials?**

Patient health and the safety of dental treatments are the primary goals of California's dental professionals and the Dental Board of California. The purpose of this fact sheet is to provide you with information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth. The Dental Board of California is required by law\* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your dentist, in turn, must provide this fact sheet to every new patient and all patients of record only once before beginning any dental filling procedure. As the patient or parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

## **Allergic Reactions to Dental Materials**

Components in dental fillings may have side effects or cause allergic reactions, just like other materials we may come in contact with in our daily lives. The risks of such reactions are very low for all types of filling materials. Such reactions can be caused by specific components of the filling materials such as mercury, nickel, chromium, and/or beryllium alloys. Usually, an allergy will reveal itself as a skin rash and is easily reversed when the individual is not in contact with the material. There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. However, there have been rare allergic responses reported with dental amalgam, porcelain fused to metal, gold alloys, and nickel or cobalt-chrome alloys. If you suffer from allergies, discuss these potential problems with your dentist before a filling material is chosen.

## **Toxicity of Dental Materials**

### **Dental Amalgam**

Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproductive toxicity. Mercury may harm the developing brain of a child or fetus. Dental amalgam is created by mixing elemental mercury (43-54%) and an alloy powder (46-57%) composed mainly of silver, tin, and copper. This has caused discussion about the risks of mercury in dental amalgam. Such mercury is emitted in minute amounts as vapor. Some concerns have been raised regarding possible toxicity. Scientific research continues on the safety of dental amalgam. According to the Centers for Disease Control and Prevention, there is scant evidence that the health of the vast majority of people with amalgam is compromised. The Food and Drug Administration (FDA) and other public health organizations have investigated the safety of amalgam used in dental fillings. The conclusion: no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy. The World Health Organization reached a similar conclusion stating, "Amalgam restorations are safe and cost effective." A diversity of opinions exists regarding the safety of dental amalgams. Questions have been raised about its safety in pregnant women, children, and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest that otherwise healthy women, children, and diabetics are not at an increased risk from dental amalgams in their mouths. The FDA places no restrictions on the use of dental amalgam.

### **Composite Resin**

Some Composite Resins include Crystalline Silica, which is on the State of California's Proposition 65 list of chemicals known to the state to cause cancer. It is always a good idea to discuss any dental treatment thoroughly with your dentist.

### **Dental Amalgam Fillings**

Dental amalgam is a self-hardening mixture of silver-tin-copper alloy powder and liquid mercury and is sometimes referred to as silver fillings because of its color. It is often used as a filling material and replacement for broken teeth.

#### **Advantages**

- Durable; long lasting
- Wears well; holds up well to the forces of biting
- Relatively inexpensive
- Generally completed in one visit
- Self-sealing; minimal to no shrinkage and resists leakage
- Resistance to further decay is high, but can be difficult to find in early stages
- Frequency of repair and replacement is low

#### **Disadvantages**

- Refer to "What About the Safety of Filling Materials"
- Gray colored, not tooth colored
- May darken as it corrodes; may stain teeth overtime
- Requires removal of some healthy tooth
- In larger amalgam fillings, the remaining tooth may weaken and fracture
- Because metal can conduct hot and cold temperatures, there may be a temporary sensitivity to hot and cold
- Contact with other metals may cause occasional, minute electrical flow

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

#### **Composite Resin Fillings**

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

#### **Advantages**

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

#### **Disadvantages**

- Refer to "What About the Safety of Filling Materials"
- Moderate occurrence of tooth sensitivity; sensitive to dentist's method of application
- Costs more than dental amalgam
- Material shrinks when hardened and could lead to further decay and/or temperature sensitivity
- Requires more than one visit for inlays, veneers, and crowns
- May wear faster than dental enamel
- May leak over time when bonded beneath the layer of enamel

#### **Glass Ionomer Cement**

Glass ionomer cement is a self-hardening mixture of glass and organic acid. It is tooth-colored and varies in translucency. Glass ionomer is usually used for small fillings, cementing metal and porcelain/metal crowns, liners, and temporary restorations.

#### **Advantages**

- Reasonably good esthetics
- May provide some help against decay because it releases fluoride
- Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- Material has low incidence of producing tooth sensitivity
- Usually completed in one dental visit

#### **Disadvantages**

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended for biting surfaces in permanent teeth
- As it ages, this material may become rough and could increase the accumulation of plaque and chance of periodontal disease
- Does not wear well; tends to crack over time and can be dislodged

#### **Resin-Ionomer Cement**

Resin ionomer cement is a mixture of glass and resin polymer and organic acid that hardens with exposure to a blue light used in the dental office. It is tooth colored but more translucent than glass ionomer cement. It is most often used for small fillings, cementing metal and porcelain metal crowns and liners.

**Advantages**

- Very good esthetics
- May provide some help against decay because it releases fluoride
- Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- Good for non-biting surfaces
- May be used for short-term primary teeth restorations
- May hold up better than glass ionomer but not as well as composite
- Good resistance to leakage
- Material has low incidence of producing tooth sensitivity
- Usually completed in one dental visit

**Disadvantages**

- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended to restore the biting surfaces of adults
- Wears faster than composite and amalgam

**Porcelain (Ceramic)**

Porcelain is a glass-like material formed into fillings or crowns using models of the prepared teeth. The material is tooth-colored and is used in inlays, veneers, crowns and fixed bridges.

**Advantages**

- Very little tooth needs to be removed for use as a veneer; more tooth needs to be removed for a crown because its strength is related to its bulk (size)
- Good resistance to further decay if the restoration fits well
- Is resistant to surface wear but can cause some wear on opposing teeth
- Resists leakage because it can be shaped for a very accurate fit
- The material does not cause tooth sensitivity

**Disadvantages**

- Material is brittle and can break under biting forces
- May not be recommended for molar teeth
- Higher cost because it requires at least two office visits and laboratory services

**Nickel or Cobalt-Chrome Alloys**

Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are a dark silver metal color and are used for crowns and fixed bridges and most partial denture frameworks.

**Advantages**

- Good resistance to further decay if the restoration fits well
- Excellent durability; does not fracture under stress
- Does not corrode in the mouth
- Minimal amount of tooth needs to be removed
- Resists leakage because it can be shaped for a very accurate fit

**Disadvantages**

- Is not tooth colored; alloy is a dark silver metal color
- Conducts heat and cold; may irritate sensitive teeth
- Can be abrasive to opposing teeth
- High cost; requires at least two office visits and laboratory services
- Slightly higher wear to opposing teeth

**Porcelain Fused to Metal**

This type of porcelain is a glass-like material that is "enameled" on top of metal shells. It is tooth-colored and is used for crowns and fixed bridges

**Advantages**

- Good resistance to further decay if the restoration fits well
- Very durable, due to metal substructure
- The material does not cause tooth sensitivity
- Resists leakage because it can be shaped for a very accurate fit

**Disadvantages**

- More tooth must be removed (than for porcelain) for the metal substructure
- Higher cost because it requires at least two office visits and laboratory services

# NOTICE OF PRIVACY PRACTICES

## THIS NOTICES DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. **This Notice takes effect February 16, 2026 and will remain in effect until we replace it.**

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact: FFDG's Privacy Officer, c/o Foothill Family Dental Group, 210 South Grand Avenue, Suite 420, Glendora, CA 91741.

## HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment of your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster relief.** We may use or disclose your health information to assist in disaster relief efforts.

**Required by law.** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with law as relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

**SUD Treatment Information.** If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in the your consent provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

### **Other Uses and Disclosures of PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

### **Your Health Information Rights**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the beginning of this Notice. You may also request access by sending us a letter to the address at the beginning of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the beginning this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of

disclosures of your health information, you must submit your request in writing to the contact information listed at the beginning of this Notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the contact information listed at the beginning of this Notice. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want to limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

**Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

#### **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, or if you disagree with a decision we have made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us at FFDG's Privacy Officer, c/o Foothill Family Dental Group, 210 South Grand Avenue, Suite 420, Glendora, CA 91741. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.