University of the Pacific

Arthur A. Dugoni School of Dentistry

Application for Dental Treatment

Patient Name: Last ________________________________ First ________________________________

Patient Birthdate: _____/_____/_____ Patient Age: ____ Male ___ Female ___ Other ________________

I hereby apply for patient status at the University of the Pacific (UOP), Arthur A. Dugoni School of Dentistry. I understand that dental treatment will be rendered by dental students or residents under the supervision of faculty members who are graduates of accredited dental schools and/or specialists in their respective field.

I hereby consent to be photographed, filmed, audiotaped or videotaped in connection with the treatment, education and research programs of the University of the Pacific. I understand and agree that all such photographs, films and tapes are the property of UOP. I further understand and agree that UOP and its faculty shall be permitted to use all or of part of my records in photographic and/or digital form in scientific writing for publication in scientific journals or for the advancement of dental education. Any identifying personal information; such as name or address, will not be exposed.

I understand that appointments (except Orthodontic appointments) could last for three or four hours and I must be available and able to sit for that length of time. I also understand that it will require more appointments to complete treatment and I am available for morning, afternoon or evening appointments. During any appointment, my medical history and dental needs will be discussed between faculty members and students while in the dental chair.

I understand that it may take up to three weeks from the completion of x-rays and/or photos for me to be assigned to a student dentist or Orthodontic resident. Any quoted fees are approximately 40% less than a private office, but services are not free. Payment is expected at the time of service or I may qualify for a payment plan to be determined if I am accepted as a patient.

I understand that UOP provides comprehensive care, which means that all of my dental needs are treated, not just a single treatment such as a root canal.

I understand and accept that some of my dental needs or expectations could be beyond the scope of treatment provided in a dental school setting and could be referred elsewhere. If that is the situation any x-rays I may have brought or any taken at UOP will provided to me upon request so I might seek treatment elsewhere.

Chart # ____________________ Assigned Student ID ____________________________

Date: ______________________ Chart# ____________________ (to be completed by staff)

Intake Form for Adult Patients

Patient *(circle selections)*

First name ______________________ Middle initial ___________ Last name _______________________________

Title: Mr. Mrs. Ms. Dr. Other ___________ I prefer to be called _____________ Birthdate: ______________

Gender: Male Female or _____________ Marital status: Single Married Separated Divorced Widowed

Home address: ___________________________________ City, State, Zip code _________________________________

Home phone: ( ) ____________________ Cell phone: ( ) ________________________

Work phone: ( ) _____________________ Email address(es): ____

Occupation: _____________________________________ Employer: ____

Preferred Language: ________________________________

The following information is collected for demographic purposes only (circle selections)

Ethnicity: Latino (Hispanic or Latino) Other (Not Hispanic or Latino) Decline to answer

Race: White Asian Black or African American Hispanic or Latino Native Hawaiian Other Pacific Islander

American Indian Alaska Native Other Decline to Answer

Closest Relative

Spouse or closest relative(s) name(s):______________________________ Relationship to patient: ________________

Address *(if different than patient address)* ____

Home phone *(if different)* ( ) _________________ Cell phone ( ) ___________________

Work phone ( ) ___________________

Current Dentist

Name: ________________________ City, State: ______________________________ Phone: ( ) ________________

Last seen: _____________ Reason: __________________________ Next appointment: __________________________

Other dentists/dental specialists now being seen: ____

Reason: ____

Physician

Name: _____________________________ City, State: _______________________ Phone: ( ) ___________________

Last seen: _________________ Reason: ____________________________ Next appointment: _____________________

Most recent physical exam: _______________Other health care providers being seen now? Yes No

Name: ____ Reason: ____

Name: ____ Reason: ____

General Information

What concerns you about your teeth? ____

Has anyone suggested that you might need orthodontic treatment? Yes No

Have you had any previous orthodontic treatment? Please describe: ____

Have any other family members been treated in this office? Please name them: __________________________________

Do you think that any of your work or leisure activities affect your teeth or jaws? Yes No

Please explain: ____

Financial Information

Who is financially responsible for this account: ____

Address *(if different than page 1)*: ____

Home phone ( ) __________________ Cell phone ( ) ____________________

Work phone ( ) _____________________ Email address(es): ____

ID#: _________________________________ Employer: ____

Insurance Information

Primary policy holder's full name: _______________________________________ Birthdate: ______________________

Insurance ID#: _________________________ Relationship to patient: __________________________

Address and phone *(if not listed above)*: ____

Employer: ___________________________________ Address: ____

Insurance company: _______________________________ Group#: ____

Does this policy have orthodontic benefits? Yes No Don't know

Secondary policy holder's full name: _____________________________________ Birthdate: ______________________

Insurance ID#: __________________________ Relationship to patient: ____________________________

Address and phone *(if not listed above)*: ____

Employer: ___________________________________ Address: ____

Insurance company: ______________________________ Group#: ____

Does this policy have orthodontic benefits? Yes No Don't know

Medical Insurance

Policy holder's full name: ____

Insurance company: _________________________________ Group#: ____

University of the Pacific, Arthur A. Dugoni School of Dentistry
Medical History

Patient Name______________________________ Birth Date____________ Chart Number_______________
(provided by UOP upon submission)

Today's Date ____________

1. **Do you have any of the following diseases or problems?**
   a. Active Tuberculosis Yes / No
   b. Persistent cough greater than 3 weeks in duration Yes / No
   c. Cough that produces blood Yes / No
   d. Been exposed to anyone with Tuberculosis Yes / No
   e. Describe any Yes answers to above questions. ____________________________

2. **What is your impression of your health?** Excellent, Good, Fair, Poor (circle)
   a. Date of last physical exam ____________________

3. **Are you now, or have you been in the past year, under the care of a physician?** Yes / No

4. **Have you had any serious illness, operation, or been hospitalized in the past 5 years?** Yes / No

5. **Have you had an organ transplant?** Yes / No

6. **Do you have a history of Endocarditis (infected heart valve)?** Yes / No

7. **Have you had open heart surgery?** Yes / No
   a. If yes, when was your heart surgery (year) ____________
   b. Was an artificial heart valve implanted? Yes / No
   c. Are you currently experiencing any complications from your surgery? Yes / No

8. **Have you had an orthopedic total joint (e.g. hip, knee, elbow, finger) replacement?** Yes / No

9. **Have you ever had any radiation therapy or chemotherapy for a growth, tumor or other condition?** Yes / No

10. **In the last 2 years, have you taken or are you now taking steroids (e.g. cortisone)?** Yes / No

11. **Do you use or have you used tobacco (smoking, snuff, chew, bidis)?** Yes / No
    a. If yes, please specify amount per day:_____
    b. For how many years ____
    c. If yes, how interested are you in stopping? Very, Somewhat, Not Interested, Smoked in the past (circle)

12. **Do you drink alcoholic beverages?** Yes / No
    a. If yes, how many drinks did you drink in the last 24 hours? _____
    b. If yes, how many drinks do you typically drink in a week?_____
    c. If yes, are you alcohol dependent? Yes / No
    d. If yes, how long have you been alcohol dependent (months)?____
    e. If yes, have you received treatment? Yes / No

13. **Do you use prescription or street drugs or other substances for recreational purposes?** Yes / No
    a. If yes, how often do you use? ___
    b. If yes, are you drug dependent? Yes / No
    c. If yes, how long have you been drug dependent (months)? ___
    d. If yes, have you received treatment? Yes / No

14. **Have you taken, are you taking or are you scheduled to begin taking?**
    a. Oral bisphosphonates: Alendronate (Fosamex, Fosamex Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid)? Yes / No
    b. If yes, what drug, dose and frequency? ______________________________
    c. If yes, what for? ____
    d. If yes, when? ____

15. **Have you taken, are you taking or are you scheduled to begin taking?**
    a. Intravenous bisphosphonates: Clodronate (Bonefos), Pamidronate (Aredia) or Zolodronic Acid (Reclast, Zometal)? Yes / No
    b. If yes, what drug, dose and frequency? ___________________________
    c. If yes, what for? ____
    d. If yes, when? ____

16. **Women only:**
    a. Are you pregnant? Yes / No
    b. Are you trying to become pregnant? Yes / No
    c. Are you nursing? Yes / No
    d. Are you taking birth control pills, fertility drugs or hormonal replacement? Yes / No

ALLERGIES:
Are you allergic to or have you had a reaction to any of the following?

18. Local anesthetics (or their preservatives) Yes / No
19. Penicillin Yes / No
20. Sulfa drugs Yes / No
21. Other antibiotics Yes / No
22. Codeine or other narcotics Yes / No
23. Aspirin Yes / No
24. Barbiturates (sedatives or sleeping pills) Yes / No
25. Hay fever/seasonal (allergic rhinitis) Yes / No
26. Animals Yes / No
27. Metals/Jewelry (nickel/chrome) Yes / No
28. Food Yes / No
29. Iodine Yes / No
30. Latex (rubber) Yes / No
31. Other/Other Medication(s) Yes / No

If Yes to any of the above, please name: ________________________Describe reaction________________________

MEDICAL CONDITIONS:
Do you have or have you had any of the following diseases, problems, or symptoms?

32. **Cardiovascular/Heart problem** Yes / No (If yes, answer **a** through **t** below)
    a. Rheumatic fever/ heart disease Yes / No
    b. Infective endocarditis Yes / No
    c. Artificial heart valves Yes / No
    d. Congenital heart defect Yes / No
    e. Heart murmur Yes / No
    f. Mitral valve prolapse Yes / No
    g. Angina (chest pain) Yes / No
    h. Heart attack Yes / No
    i. Heart failure Yes / No
    j. Coronary heart disease Yes / No
    k. High blood pressure Yes / No
    l. Low blood pressure Yes / No
    m. Arteriosclerosis Yes / No
    n. Palpitations Yes / No
    o. Arrhythmia (irregular heart beat) Yes / No
    p. Shortness of breath Yes / No
    q. Swelling of the ankles Yes / No
    r. Pacemaker Yes / No
    s. Implantable defibrillator Yes / No
    t. Sleep on two or more pillows Yes / No

33. **Respiratory/Lung problem** Yes / No (If yes, answer **a** through **j** below)
    a. Asthma Yes / No
    b. Emphysema/COPD Yes / No
    c. Tuberculosis Yes / No
    d. Sarcoidosis Yes / No
    e. Pneumonia Yes / No
    f. Sinusitis Yes / No
    g. Bronchitis Yes / No
    h. Persistent cough Yes / No
    i. Sleep apnea Yes / No
    j. Snoring Yes / No

34. **Diabetes/Endocrine disorder** Yes / No (If yes, answer **a** through **c** below)
    a. Diabetes Yes / No
    b. Thyroid problems Yes / No
    c. Adrenal gland disorder Yes / No

35. **Kidney/Urogenital disorder** Yes / No (If yes, answer **a** through **e** below)
    a. Kidney stones Yes / No
    b. Renal failure/insufficiency Yes / No
    c. Dialysis Yes / No
    d. Prostate Yes / No
    e. Frequent urination Yes / No

36. **Cancer or Tumors** Yes / No (If yes, answer **a** and **b** below)
    a. Malignant Yes / No
    b. Benign Yes / No

37. **Neurologic/Nerve problem** Yes / No (If yes, answer **a** through **q** below)
    a. Stroke Yes / No
    b. TIA (transient ischemic attack) Yes / No
    c. Seizures/epilepsy Yes / No
    d. Multiple sclerosis Yes / No
    e. Parkinson's disease Yes / No
    f. Neuropathies Yes / No
    g. Dementia/Alzheimer's (memory loss) Yes / No
    h. Headache Yes / No
    i. Fainting or dizzy spells Yes / No
    j. Weakness Yes / No
    k. Feeling of tingling or numbness Yes / No
    l. Mental health disorder Yes / No
    m. Post-traumatic stress disorder Yes / No
    n. Obsessive/compulsive disorder
    o. ADD/ADHD (attention deficit disorder) Yes / No
    p. Feelings of anxiety Yes / No
    q. Feelings of depression Yes / No

38. **Blood/Hematologic disorder** Yes / No (If yes, answer **a** through **i** below)
    a. Anemia Yes / No
    b. Thalassemia Yes / No
    c. Sickle cell disease/trait Yes / No
    d. Deep vein thrombosis Yes / No
    e. Bruise easily Yes / No
    f. Leukemia Yes / No
    g. Lymphoma Yes / No
    h. Multiple myeloma Yes / No
    i. Bleeding disorders Yes / No

39. **Gastrointestinal (GI) disorder** Yes / No (If yes, answer **a** through **i** below)
    a. Cirrhosis/chronic hepatitis Yes / No
    b. Jaundice (skin/eyes turn yellow) Yes / No
    c. Hepatitis Yes / No
    d. Heart burn Yes / No
    e. Acid reflux (GERD) Yes / No
    f. Gall stones Yes / No
    g. Ulcers Yes / No
    h. Crohn's disease Yes / No
    i. Irritable bowel syndrome Yes / No

40. **Musculoskeletal/Connective tissue disorder** Yes / No (If yes, answer **a** through **h** below)
    a. Arthritis Yes / No
    b. Osteoporosis Yes / No
    c. Gout Yes / No
    d. Temporomandibular joint disorder Yes / No
    e. Lupus Yes / No
    f. Sclerodema Yes / No
    g. Fibromyalgia Yes / No
    h. Joint replacement Yes / No

41. **Infectious disease** Yes / No (If yes, answer **a** through **f** below)
    a. HIV Yes / No
    b. AIDS Yes / No
    c. Methicillin-resistant Staph aureus (MRSA) Yes / No
    d. STD (sexually transmitted disease) Yes / No
    e. Cold sores Yes / No
    f. Mononucleosis Yes / No

42. **Head/Eye/Ear/Nose/Throat problem** Yes / No (If yes, answer **a** through **e** below)
    a. Vision problems Yes / No
    b. Wear contact lenses Yes / No
    c. Glaucoma Yes / No
    d. Cataract Yes / No
    e. Hearing impairment Yes / No

43. **Dermatologic/Skin problem** Yes / No (If yes, answer **a** and **b** below)
    a. Psoriasis (dry skin) Yes / No
    b. Other______________________

44. **Eating disorder** Yes / No (If yes, answer **a** and **b** below)
    a. Bulimia Yes / No
    b. Anorexia Yes / No

45. **Immunosuppression** Yes / No

46. **Family history of diabetes: If yes, who?___________________**

47. **Family history of heart disease: If yes, who?__________________**

48. **Family history of cancer/tumors: If yes, who?____________________**

49. **Are you concerned about your safety at home?** Yes / No

50. **Do you have any other problem, disease or condition not listed above?** Yes / No
    If yes, please describe:____

51. **Are you taking any Anticoagulant or Blood Thinner medication?** Yes / No
    If yes, please describe: ____

52. **If you are taking, have recently (within the last month) taken, or are supposed to be taking any medications (prescription, over the counter) please specify medication(s), dosage and frequency**

Medication: ____________________________ Medication: ____________________________
Dose: _________________________________ Dose: _________________________________
Frequency: _____________________________ Frequency: _____________________________

Medication: ____________________________ Medication: ____________________________
Dose: _________________________________ Dose: _________________________________
Frequency: _____________________________ Frequency: _____________________________

Medication: ____________________________ Medication: ____________________________
Dose: _________________________________ Dose: _________________________________
Frequency: _____________________________ Frequency: _____________________________

Medication: ____________________________ Medication: ____________________________
Dose: _________________________________ Dose: _________________________________
Frequency: _____________________________ Frequency: ____________________________

Medication: ____________________________ Medication: ____________________________
Dose: _________________________________ Dose: _________________________________
Frequency: _____________________________ Frequency: _____________________________

Medication: ____________________________ Medication: ____________________________
Dose: _________________________________ Dose: _________________________________
Frequency: _____________________________ Frequency: _____________________________

Medication: ____________________________ Medication: ____________________________
Dose: _________________________________ Dose: _________________________________
Frequency: _____________________________ Frequency: _____________________________

PATIENT SIGNATURE_________________________________ DATE_____________________

Revised 2/23/2016

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PATIENT CENTERED CARE POLICY
UNIVERSITY OF THE PACIFIC ARTHUR A. DUGONI SCHOOL OF DENTISTRY

Thank you for selecting the University of the Pacific as your oral healthcare provider. Our goal is to provide you with an excellent experience while you are here. This document will spell out what that means.

POLICY

Interactions between patients, students and employees (staff, managers, and faculty) and decisions resulting from those interactions will focus on the provision of patient centered care as described in the Clinic Mission Statement.

CLINIC MISSION STATEMENT

To provide patient centered, evidence based, oral healthcare in a humanistic educational environment.

The intent of the Clinic Mission Statement is to focus faculty, staff, and students on the delivery of excellent patient care. We will always strive to provide excellent care to our patients and excellent educational experiences for our students. Excellent patient care is an excellent learning experience. At those times when we must choose between patient care and teaching effectiveness, patient care will take precedence.

There are four parts to the Clinic Mission Statement:

- Patient-centered care includes a wide range of objectives such as being prompt, efficient, responsible, communicative, engaging, focused, and adaptable. It encourages faculty and staff to be excellent role models, attentive to individual patient's needs, and focused on service. It requires that treatment decisions be based in part on individual patient values. The private practice model is the patient care model to which we aspire.
- Evidence based decision making involves the use of scientific evidence to help make treatment decisions. It is used in conjunction with patient values to determine the best course of action for each patient.
- Quality oral healthcare involves providing treatment to our patients that meets community standards of care for all procedures. It means providing that care to patients with varying needs and expectations.
- Humanistic education is based on honest communication of clear expectations along with positive support for diligent effort. It involves treating all people with dignity and respect at all times. Faculty and staff must be models of the profession's highest standards. Students are expected to set equally high standards for their behavior. The educational environment will be intellectually stimulating, progressive in scope, and evidence based.

University of the Pacific Arthur A. Dugoni School of Dentistry
Financial Policies

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment arrangements. Pacific is not a free clinic. **Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our clinic financial staff**. Students are not authorized to make any payment arrangements for your treatment, nor are they authorized to offer discounted treatment. ***These financial policies do not apply to Orthodontic treatment.***

Payment Options

- We accept cash, check, MasterCard, Visa, Discover, American Express, Electronic Funds Transfer or ATM debit cards.

- If you qualify, we can set up a **Contract Payment Plan** that will allow you to pay for your dental care over time free of interest charges.
  Your treatment plan total must be a minimum of $1000 with a minimum payment of $84 per month. Our standard contracts are paid over 12 consecutive months.

  For Contract Payment Plans totaling $1000 up to $4999, you must provide the following:

    - Valid photo ID (valid driver's license, student I.D. card, passport)
    - Proof of address (utility bill, rental agreement)
    - Proof of employment or bank account information
    - Active credit card

  For Contract Payment Plans in excess of $5000, you may be asked to sign authorization to obtain your credit history, in addition to meeting the above requirements. If you do not meet the Contract Payment Plan qualifications, a qualified co-signer may be accepted. We ask for a down payment at the time the Contract Payment Plan is set up. The down payment must be equal to at least one month's payment. Certain procedures (*i.e.* crowns, implants, dentures) require an additional **down payment equal to 50%** of the fee for those procedures. The Contract Payment Plan will be calculated for the full cost of your treatment plan.

Private Insurance

If you have private insurance, prior authorization may be required by your insurance company before the start of treatment. We will bill your insurance company as a courtesy to you upon completion of each procedure rendered. By signing this document, you are authorizing the University of Pacific to submit claims on your behalf for reimbursement directly to the University. The contract for dental insurance exists between you and your dental insurance company. Any prior authorization by your insurance company is not a guarantee of payment. If your insurance company denies payment for any procedure for any reason, you will be responsible for the full cost of the treatment. You will be reimbursed for any overpayment on your contract due to insurance payments or adjustments applied to your account.

Denti-Cal Program

If you are eligible for the Denti-Cal program, you are required by the State of California to provide us with your current Denti-Cal Identification card and photo ID. Your eligibility is determined monthly by your dental care provider. Any share of cost or changes to your eligibility could make you personally responsible for payment of treatment provided at our dental clinic. **The Denti-Cal program does not cover all dental procedures**. If you elect to have any treatment that is not covered by the Denti-Cal program, you will be responsible for the cost.

Payment Terms

You are obligated to pay your monthly contract amount regardless of whether you receive a statement. If you are late on your monthly contract payment by more than 60 days, your contract may be terminated at which time any balance due for services rendered will become due and payable immediately. Thereafter, you will be required to pay in full at time of treatment. Account balances not paid within 90 days and determined delinquent by the University of the Pacific, will be sent to collections and you will be responsible for any fees and penalties assessed to you by the collection agency.

If you have any questions about the above information please do not hesitate to ask our clinic financial staff.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

AS A PATIENT AT THE DENTAL SCHOOL, YOU HAVE THE RIGHT TO:

1. See your student dentist or resident and/or an attending instructor every time you receive dental treatment.
2. Considerate, ethical and confidential treatment that meets the standard of care in the profession. Your treatment plan will be based on current scientific evidence and patient values.
3. Continuous care until treatment is completed or you decide to discontinue care.
4. Request complete and current information about your dental condition in words you can understand.
5. Know in advance the type and expected cost of treatment.
6. Expect all people involved in your care to use proper infection controls.
7. Receive emergency care in a timely manner.
8. Informed consent for all dental treatment planned for you, including recommended treatment, alternative treatment, options to refuse treatment and the risks of no treatment.
9. Discuss issues involving your financial account with a staff member.
10. Request and inspect copies of your records, including treatment notes, x-rays, and photographs.
11. Ask questions about your care with your student dentist, resident and/or supervising faculty member. You may also discuss unresolved questions with Group Practice Leader or department Managers. The Patient Relations Liaison is also available at 415-351-7124 for concerns that remain challenging.

AS A PATIENT AT THE DENTAL SCHOOL, YOU UNDERSTAND AND AGREE TO:

1. Conduct all interactions with students, residents, staff, and faculty in a mutually considerate manner. The dental school retains the right to limit or restrict services to anyone for behaviors deemed inappropriate by the faculty or staff.
2. Give honest and complete information when requested.
3. Update the dental school on changes to your contact information (e.g. telephone, mailing address).
4. Be on time for appointments. You must give at least 24-hour notice of cancellation for any appointments. Patients with 3 missed appointments, frequent cancellations without 24 hour notice, or repeated unsuccessful attempts to arrange for an appointment may be discontinued from further treatment.
5. Pay for all services rendered.
6. Arrive for your appointments free from the influence of alcohol or recreational drugs.
7. Adults with appointments are asked to avoid bringing children (or others requiring your care) to appointments.
8. Keep the building free of pets. (ask to see our separate policy for Service and Support Animals)
9. Follow through on recommended treatment, postoperative instructions, and home care.
10. Agree to dental x-rays as necessary and appropriate for examination, diagnosis, and treatment.
11. Allow the School to take patient photographs to document your general presenting conditions, case progress, and completion of treatment. These photographs may be used for educational purposes within the School of Dentistry. Additionally, de-identified (pursuant to HIPAA) photographs may be shared externally in publications, professional presentations, with other healthcare institutions or professional associations, or by students when applying to post graduate programs at other dental schools to illustrate treatment they have provided.

Patient Signature ____ Date ______________________

Revised September 2016

The Facts About Fillings

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 (43-54o/o) and an alloy powder (46-57o/o) 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 Materials -Advantages & Disadvantages

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 over time • 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 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 small risk of leakage if bonded only to enamel does not corrode

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 • 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 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 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 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 re- moved 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 use 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 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; m ay 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 is a type of porcelain that 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

Gold alloy is a gold-colored mixture of gold, copper, and other metals and is used mainly for crowns and fixed bridges and some 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 • Wears well; does not cause excessive wear to opposing teeth • Resists leakage because it can be shaped for a very accurate fit

Disadvantages

• Is not tooth colored; alloy is yellow • Conducts heat and cold; may irritate sensitive teeth • High cost; requires at least two office visits and laboratory serv1ces

University of the Pacific
Arthur A. Dugoni School of Dentistry

NOTICE OF PRIVACY PRACTICES

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

OUR LEGAL DUTY

We are required by law to maintain the privacy of your protected health information (PHI). We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your 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 April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to 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. Before we make a significant change in our privacy practices, we will change this Notice, and post the new Notice clearly and prominently, and will make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. Some information 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 or disclose your health information for your treatment. For example we may disclose your health information to a specialist treating you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. 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 our healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. As an educational institution your health information may be accessed by students, residents, faculty and staff of the School of Dentistry during the course of clinical operations.

Friends, Family, and Persons Involved in Your Care: We may disclose your health information to your family, friends or any other individual identified by you when they are involved in your care or in the payment for 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. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

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

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 institutions, or law enforcement officials having lawful custody, the protected health information of an inmate or patient under certain circumstances.

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 laws 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 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 carry out 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Other Uses and Disclosures of PHI: Your authorization is required for use or disclose of PHI for marketing, and 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 taken action 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. Pre-made request forms are available from any receptionist. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the format you request unless we cannot practically do so. We will charge you a reasonable cost-based fee for expenses such as supplies and labor. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for more information. If we deny your request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. You must submit your request in writing to the Privacy Official**.** If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. 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 the limits to apply. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. 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 healthcare 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 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 and explain your rights.

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

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

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, 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 will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact information:

Ms. Lindsey Green
Patient Relations Liaison / Privacy Officer
415.351.7124
lgreen@pacific.edu

All other calls to the clinic: 415.929.6501

Effective: April 2003 Updated: January 2016

The University of the Pacific, Arthur A. Dugoni School of Dentistry, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The School of Dentistry does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The School of Dentistry:
Provides free aids and services to people with disabilities to communicate effectively with us, such as;

- Qualified sign language interpreters,
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as;

- Qualified interpreters
- Information written in other languages

If you need these services, contact Lindsey Green. If you believe that The School of Dentistry has failed to provide these services or discriminated in another way on the basis of race, color national origin, age, disability, or sex, you can file a grievance with:

Lindsey Green, Patient Relations Liaison
155 5th Street, San Francisco, CA 94103
Lgreen@pacific.edu
(415) 351-7124, (415) 929-6699 (fax)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Lindsey Green, Patient Relations Liaison is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
1-800-868-1019, 1-800-537-7697 (TDD)

“ATENCIÓN: si habla (Español), tendrá disponibles servicios de asistencia de idiomas sin costo. Si siente que necesita estos servicios, consulte a su recepcionista, residente o practicante en odontología”.

“注意：如果您说（中文），则可向您提供免费的语言援助服务。如果您觉得您需要此等服务，请告知您的学生牙科医生、住院医生或前台接待员”

"تنبيه: إذا كنت تتحدث اللغة العربية، فإن الخدمات المساعدة للغات متوفرة لك مجاناً. إذا شعرت بأنك في حاجة إلى هذه الخدمات رجاء طلب تلك الخدمة من طبيب الأسنان الطالب او المقيم أو موظف الاستقبال."

«ВНИМАНИЕ! Если ваш родной язык heccrbq, вы можете воспользоваться бесплатными переводческими услугами. Если вы считаете, что вам нужны такие услуги, обратитесь с вопросом о них к студенту стоматологического факультета, жильцу кампуса или к администратору».

“โปรดทราบ: หากคุณพูด**ภาษาไทย** เรามีบริการความช่วยเหลือทางภาษาโดยไม่มีค่าใช้จ่ายให้กับคุณ หากคุณรู้สึกว่าคุณต้องการบริการเหล่านี้ โปรดสอบถามกับนักศึกษาทันตแพทย์ของคุณ แพทย์ประจำบ้าน หรือพนักงานต้อนรับ

“សូមមើលទីនេះ ៖ បើអ្នកនិយាយភាសាខ្មែរ យើងខ្ញុំមានផ្តល់ជូនសេវាកម្មបកប្រែភាសាដល់អ្នកដោយឥតគិតថ្លៃ ។ បើអ្នកគិតថាចង់ប្រើសេវាកម្មនេះ សូមប្រាប់សិស្សទន្តពេទ្យ អ្នកស្នាក់នៅ ឬអ្នកទទួលភ្ញៀវឲ្យបានដឹង” ។

«**توجه:** اگر به زبان فارسی صحبت می‌کنید، خدمات زبانی به صورت رایگان برای شما موجود است. اگر احساس می‌کنید که به این خدمات نیاز دارید، لطفاً از دانشجوی دندانپزشکی، رزیدنت، یا مسئول پذیرش خود، درباره نحوه دریافت این خدمات سؤال کنید.»

「注記：（日本語）をお話しの場合、無償で言語補助サービスをご利用いただけます。サービスの利用をご希望の場合、学生の歯科医、寮生または受付までお申し出ください」。

«ՈՒՇԱԴՐՈՒԹՅՈՒՆ. եթե խոսում եք հայերեն լեզվով, լեզվի աջակցման ծառայությունն անվճար հասանելի է Ձեզ: Եթե զգում եք, որ այդ ծառայության կարիքն ունեք, հարցրեք Ձեր ուսանողական ատամնաբույժին, ռեզիդենտին կամ ընդունարանի աշխատողին»:

"कृपया ध्यान दें : यदि आप हिंदी बोलते हैं तो आपके लिए भाषा सहायता सेवा नि:शुल्क उपलब्ध है. यदि आपको लगता है कि आपको इस सेवा की आवश्यकता है तो कृपया अपने विद्यार्थी चिकित्सक, निवासी चिकित्सक या स्वागतकर्मी (रिसेप्शनिस्ट) से कहें."

“ਕਿਰਪਾ ਕਰਕੇ ਧਿਆਨ ਦੇਵੋ : ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿਚ ਭਾਸ਼ਾ ਸੇਵਾ ਉਪਲਬਧ ਹੈ। ਜੇਕਰ ਤੁਹਾਨੂੰ ਲੱਗਦਾ ਹੈ ਕਿ ਤੁਹਾਨੂੰ ਇਸ ਸੇਵਾ ਦੀ ਜ਼ਰੂਰਤ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਵਿਦਆਰਥੀ ਚਿਕਿਤਸਕ, ਨਿਵਾਸੀ ਚਿਕਿਤਸਕ ਜਾਂ ਸੁਆਗਤ ਕਰਮੀ (ਰਿਸੈਪਸ਼ਨਿਸਟ) ਨਾਲ ਗੱਲ ਕਰੋ।”

“주의: (한국어)를 사용하는 경우 무료 언어 지원 서비스가 제공됩니다. 이러한 서비스가 필요한 경우 치대 학생, 수련의 또는 접수 담당자에게 문의해 주십시오.”

“ATENSYON: kung nagsasalita kayo ng Tagalog, ang mga serbisyo sa tulong sa wika, libre, ay mapapakinabangan ninyo. Kung sa pakiramdam ninyo ay kailangan ninyo ang mga serbisyong ito, mangyaring magtanong sa inyong estudyante ng dentistry, sa residente o sa receptionist”.

"CEEB TOOM: yog tias koj hais lus Hmoob, kev pab txhais lus, dawb tsis them nyiaj, muab los rau koj. Yog tias koj xav tias koj yuav kev pab txhais lus thov nug tus kws kawm ntawv kho hniav, tus nyob kho mob, los tus txais siab dawb paug rau kev pab."

“CHÚ Ý: nếu quý vị nói tiếng Việt, dịch vụ trợ giúp ngôn ngữ được cung cấp miễn phí cho quý vị. Nếu quý vị thấy cần các dịch vụ này, vui lòng yêu cầu sinh viên nha khoa, bác sĩ thực tập hoặc lễ tân của mình”

Authorized Forms of Communication

University of the Pacific School of Dentistry can send you various notices via electronic methods. An example would be appointment reminders, letters, clinic updates and requests for information. In order to communicate with you using these methods (text or email) we need your authorization to do so. Not all communications will use electronic methods; we will still call you and send communications through the US Postal service on occasion.

Please note that electronic transmissions are not secure and are at risk for access by third parties. To help ensure your privacy, to the best of our ability, no personal identifying information (E.g. Birthdates, ID numbers) will be included in transmissions.

If you would like to receive communications by the methods above, please sign below. You may choose one or the other or both.

I consent for the University of the Pacific School of Dentistry to communicate with me via text messages and/or email. I understand that the responsibility of attending appointments or cancelling them still rests with me. I understand that transmission may not be secure. I agree to advise the school if my mobile number changes or my email service is no longer viable.

Text ___ Yes ___ No   Email ___ Yes ___ No

Signed ____   Date ___________________________

Financial Policies

The undersigned authorizes the University of the Pacific to submit claims (on patient's behalf) to insurance, Denti-Cal, or other third party payer(s) and to disclose health information to the extent necessary to obtain payment. The undersigned also assigns benefits paid by insurance, Denti-Cal or other third party payer(s) directly to the University of the Pacific. In consideration of the dental services provided, the undersigned assigns to the University of the Pacific any benefits to which the undersigned may be entitled to receive, including without limitation any such benefits due or claims the undersigned has under or pursuant to a benefit plan governed under ERISA, 29 USC sec 101 et seq.

I have reviewed the University of Pacific's financial policies as stated above and I understand, agree to be bound by, and accept the responsibility of cooperating with these policies. I understand that I will be responsible for all financial balances resulting from treatment received that is not paid by my insurance company, Denti-Cal or any third party payee.

Signed ____   Date _____________________________

University of the Pacific
School Of Dentistry

Dental Materials Fact Sheet Acknowledgement of Receipt

I acknowledge that I have received the Dental Materials Fact Sheet developed by the Dental Board of California. I understand that this fact sheet has been provided to me in an effort to ensure I am fully informed of the variety of materials available for dental restorations. I understand that I should review this information to make a fully informed decision regarding dental restorative treatment. I also understand that if I have questions or concerns regarding this information that it is my right to have a discussion regarding this aspect of my care with my student or supervising clinical faculty member before undertaking any restorative treatment.

_______________________________________ _______________________________________

Signed Date

Acknowledgement of Receipt of Notice of Privacy Practices

** You Have the Right to Refuse to Sign This Document**

I, (print name) ____ have read and/or received a copy of this office's Notice of Privacy Practices.

_______________________________________ _______________________________________

Signed Date

For Office 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
- ◯ Communication barriers prohibited obtaining acknowledgement
- ◯ An emergency situation prevented us from obtaining acknowledgement
- ◯ Other (please specify)