Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Middle Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Business Phone _____

Cell Phone _____ Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Middle Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Insurance Company _____ Phone _____

Insurance Email _____ Effective Date _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____ Effective Date _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides

Dental History

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

☐Y ☐N Bad breath
☐Y ☐N Food collection between teeth
☐Y ☐N Periodontal treatment
☐Y ☐N Sensitivity to sweets
☐Y ☐N Bleeding gums
☐Y ☐N Grinding or clenching teeth
☐Y ☐N Sensitivity to cold
☐Y ☐N Sensitivity when biting
☐Y ☐N Clicking or popping jaw
☐Y ☐N Loose teeth or broken fillings
☐Y ☐N Sensitivity to hot
☐Y ☐N Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Medical History

Physician's name _____ Address _____ Phone _____

Physician's Email _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐Y ☐N If yes, describe _____

Are you currently under physician care? ☐Y ☐N If yes, describe _____

Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate date(s) _____

Have you ever taken Fen-Phen/Redux? ☐Y ☐N

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N

Check Y for yes or N for no if you have or have not had the following:

☐Y ☐N AIDS/HIV Positive
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Arthritis, Rheumatism
☐Y ☐N Artificial heart valves
☐Y ☐N Artificial joints
Describe _____
☐Y ☐N Asthma
☐Y ☐N Atopic (allergy prone)
☐Y ☐N Back problems
☐Y ☐N Blood disease
☐Y ☐N Bruise easily
☐Y ☐N Cancer
☐Y ☐N Chemical dependency
☐Y ☐N Chemotherapy
☐Y ☐N Circulatory problems
☐Y ☐N Cortisone treatments
☐Y ☐N Cough, persistent
☐Y ☐N Cough up blood
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Fainting
☐Y ☐N Food allergies
☐Y ☐N Glaucoma
☐Y ☐N Headaches
☐Y ☐N Heart murmur
☐Y ☐N Heart problems
Describe _____
☐Y ☐N Hemophilia/ Abnormal bleeding
☐Y ☐N Herpes
☐Y ☐N Hepatitis
Describe _____
☐Y ☐N High blood pressure
☐Y ☐N Jaw pain
☐Y ☐N Kidney disease or malfunction
☐Y ☐N Liver disease
☐Y ☐N Material allergies (latex, wool, metal, chemicals)
☐Y ☐N Mitral valve prolapse
☐Y ☐N Nervous problems
☐Y ☐N Pacemaker/Heart surgery
☐Y ☐N Psychiatric care
☐Y ☐N Rapid weight gain or loss
☐Y ☐N Radiation treatment
☐Y ☐N Respiratory disease
☐Y ☐N Rheumatic fever
☐Y ☐N Scarlet fever
☐Y ☐N Shingles
☐Y ☐N Shortness of breath
☐Y ☐N Skin rash
☐Y ☐N Spina Bifida
☐Y ☐N Stroke
☐Y ☐N Dental or Surgical implant
Describe _____
☐Y ☐N Swelling of feet or ankles
☐Y ☐N Thyroid disease or malfunction
☐Y ☐N Tobacco habit
☐Y ☐N Tonsillitis
☐Y ☐N Tuberculosis
☐Y ☐N Ulcer/Colitis
☐Y ☐N Venereal disease

List medications you are currently taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.
Advance notice of 48 hours is required for any cancellation, or a fee may be charged.

#FM-0880

Financial & Office Agreement

Thank you for choosing **Dr. Brian Sheaff** for your dental health needs. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health.

We do not want finances to be an issue for our patients. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our policy:

1. **Payment is due at the time service is provided.** We accept cash, personal checks, cashier's checks, money orders, Visa, Mastercard, and Discover.
2. Patients who carry dental insurance understand that **all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance.** As a courtesy to you we will help you process all your insurance claims. We ask that you **pay the deductible and co-payment**, which is the estimated amount not covered by your insurance company at the time we provide service to you. **We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage.** Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. **If your claim is denied or the treatment is down coded and/or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time.** We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. **If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility.** ____ (please initial) Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

Please Note:

Minor Patients – The adult accompanying the minor is responsible for the payment on the account or provide us signed paperwork from the responsible parent.

Separated & Divorced Couples with Dependent Children – It is the policy of this office to charge the parent that brings the children in for their dental treatment. Please make arrangements for payment with other parent before dental treatment is rendered. We can provide a treatment cost estimate before your scheduled appointment.

Statements - All patients with an outstanding balance will receive a statement each month. All accounts over 90 days will be subject to our collection agency.

Returned Checks – A fee of $50.00 will be charged for any returned check. We will not be able to accept any future checks once a check has been returned. We will also forward a copy of returned check to our collection agency.

Financial & Office Agreement

I assign directly to **Dr. Brian Sheaff**, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dental practice may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect this account. Additionally, **by signing this form I authorize Dr. Brian Sheaff to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.**

Remember to keep all your scheduled Dental Appointments.

- Broken Appointment Charges:
  - $$50 for all recall appointments
  - $150 per hour non-refundable fee for treatment appointment
- Rescheduling/Cancellation policy:
  - 48 hours for recall appointments
  - 1 week for treatment appointments

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

_____ _____

Print Name of Responsible Party Date

_____

Signature of Responsible Party

_____

Patient's Name

CREDIT CARD AUTHORIZATION FORM

Thank you for choosing our practice for your dental needs. We are pleased to offer you the option of a credit card charge and ask that you complete the following authorization:

Instructions: To pay by credit card or credit card, please complete both sections below.

CREDIT CARD HOLDER INFORMATION
Please check credit card type:

- ❑ Visa
- ❑ MasterCard
- ❑ Discover
- ❑ American Express

Card number: _____ Expiration date: _____ /_____ (MM/YY)

Exact Name as it appears on the card: _____

Patient Name: _____

Billing Zip Code: _____ Primary Phone Number: _____

DISCLAIMER:

Cardholder agrees that all information provided is accurate and complete. Cardholder acknowledges that if a payment plan arrangement has been failed, the promised payment will automatically be charged to the above card. Cardholder's signature will be kept on the file for automatic charge of any unpaid balance due after dental benefit payment is received. Cardholder agrees to the above card being charged in file for account balance if it has not been paid within 60 days.

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and health care operations.

- **TREATMENT** means providing, coordinating or managing health care and related services by on or more health care providers. A example of this would include teeth cleaning services.
- **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **HEALTH CARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and customer service. An example would be an internal quality assessment review.

We may also create and distribute identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be interest to you.

Any other uses or disclosures will be made only with you written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to you protected information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses or disclosures of protected health information, including those related to disclosure to family members, other relatives close personal friends, or any other person identified by you. We are, however, not required to agree in writing to remove it.
- The right to reasonable request to receive confidential communications or protected health information from us by alternative means or at a alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notices of our legal duties and privacy practices with respect to protected health information.

The notice is effective as of April 14, 2003 and we are required to abide by the terms of *Notice of Privacy Practices* and to make it the new notice provisions effective for all protected health information that we maintain. We will not post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services Office of Civil Rights about violations of the provisions of this notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Dr. Brian Sheaff
www.drsheafdentistry.com
(925)689-3450

For more information about HIPPA or to file a complaint:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201
(202) 619-0257
Toll Free (877) 696-6775

CALIFORNIA DENTAL NETWORK
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.

Effective April 14, 2004

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we provide you with this notice of our privacy practices and legal duties, as well as your rights, regarding any of your protected health information (PHI) that we maintain. California Dental Network (CDN) will follow the privacy practices that are described in this notice, and will also comply with any stricter federal or state laws that may apply. CDN reserves the right to change our privacy policies and to amend this notice from time to time. Updated copies of our Privacy Notice may be obtained from our website at www.caldental.net.

Use and Disclosure of your Protected Health Information (PHI)
The following is a summary of when CDN may, as permitted by law, use or disclose your PHI without your authorization:

- For Payment Purposes- activities to make payments to and/or collect payments (including premiums) from you or third parties and to determine or maintain coverage, including providing information about your coverage or treatment to other health care entities to coordinate payment of benefits, as well as activities related to pre-authorization for certain dental services.
-
- For Treatment Purposes- such as forwarding copies of records submitted to CDN by your general dentist to specialists or other general dentists who will be providing care and /or second opinions about care.

- For Health Care Administration Purposes- activities essential to CDN's function as a licensed Health Care Service Plan, including, but not limited to: quality assessment and improvement activities, accreditation, certification, licensing, or credentialing activities, healthcare provider qualification and competence review, customer service activities such as answering enrollee inquiries and resolving grievances, activities designed to improve health care, and /or reduce health care costs, and underwriting and premium rating activities.

- To Provide Information on Health-Related Benefits and Alternatives, Programs or Products- CDN may provide you with information on health-related products or services, or recommend treatment options or alternatives that may be of interest to you.

- Business Associates- where services are provided to CDN through contracts with third- party Business Associates (example: independent insurance brokers), and these services involve the use or disclosure of PHI, CDN will have a written contract or contract addendum that requires the Business Associate to maintain the same privacy standards as those maintained by CDN and its employees.

- To Parents or Guardians of a Minor, Court-Appointed Guardian of an Adult, Spouse or other close relative, or personal representative –CDN may disclose health information relevant to that person's involvement in your health care or payment. CDN employees will use their best judgment to verify the identity and relationship of the persons in question, and the appropriateness of disclosing the information.

- To an Employer- for purposes of administering benefits if your benefit program is sponsored by your employer, or if health care services were provided with specific prior written request and expense of the employer, and are relevant in a grievance, arbitration or lawsuit, or describe health limitations that permit you to leave from work or that limit job related activities.

- Other Purposes- Public health activities, health oversight by government agencies, Worker's Compensation purposes, to assist in disaster relief efforts, to avert a serious threat to health or safety, concerning victims of

abuse, neglect, or domestic violence, information about decedents to coroners, medical examiners, and funeral directors, for research purposes (provided research has been approved by an institutional review board and insures privacy of your PHI), for organ donation purposes, for FDA reporting relative to adverse effects or product recalls, for underwriting and fundraising (subject to certain restrictions), for military and veterans as required by military command, for national security activities as authorized by law, for inmates (to the correctional institution or law enforcement agency in custody), for judicial and administrative purpose (including the defense by CDN of a legal action or proceeding brought by you), in response to a court order, subpoena, or law enforcement search warrant, for use in creating summary information that can no longer be traced to you, and as otherwise required by federal, state, or local law.

Authorized Disclosures

CDN will not disclose your personal health information without your prior written authorization, if such disclosure is not permitted by law. If you give us authorization to use your PHI, you may revoke that authorization in writing at any time. A revocation of authorization will only affect uses and disclosures made after the revocation is received.

Your Rights Regarding Your Health Information

- Right to inspect and copy- Subject to certain limitations you have the right to inspect and copy PHI that CDN possesses. The request must be made in writing, and CDN may charge a reasonable fee for locating and copying the information. CDN will act on your request within 30 days of receipt.
-
- Right to request a restriction- you may ask that CDN limit how your PHI is used and disclosed. CDN is not required to agree to your request, but if we do the limitations will be put in writing and CDN will abide by them except in emergency situations. You may not limit uses and disclosures that are required by law.

- Right to amend your PHI-If you believe that health records that CDN created about you are inaccurate or incomplete you may file a written request for amendment. If CDN did not create the information we will refer you to the source, such as your dental provider. In certain circumstances CDN may deny a request to amend. If your request is denied you have the right to file a statement of disagreement with us, and CDN has a right to file a rebuttal (and provide you with a copy of it).

- Right to confidential or alternative communications-You may request in writing that CDN communicate with you by reasonable alternative means or at an alternative address, if communications about your PHI to your home address could endanger you.

- Right to an accounting-You have the right to receive an accounting of CDN's disclosures of your PHI except for disclosures made for treatment, payment, or health care operations, or when such accounting is restricted by law. The request must be made in writing, include the time period requested, must be for a time period starting no earlier than April 14, 2004, and may not go back more than 6 years.

- Right to a paper copy of this notice- You have a right to request a paper copy of this notice at any time, even if you have previously gotten this notice electronically (by e-mail or from our website at www.caldental.net).

Complaints

If you feel your privacy rights have been violated you may file a written complaint with CDN at:

California Dental Network
Attn: Privacy Officer
23291 Mill Creek Drive, Ste. 100
Laguna Hills, CA 92653

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

I understand that under the **Health Insurance Portability & Accountability Act of 1996** (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
-
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time as the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payments, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____	_____
Patient Name:	Parent/Guardian Name:
_____	_____
Patient Signature:	Parent/Guardian Signature:
	_____
	Relationship to Patient:
_____	_____
Date:	Date:

OFFICE USE ONLY

I attempted to obtain the patient's signature in the acknowledgement on this *Notice of Privacy Practices Acknowledgment*, but was unable to do so as documented below:

Date:	Initials:	Reason:

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

The Dental Board of California
Dental Materials Fact Sheet

Adopted by the Board on October 17, 2001

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

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

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

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Both the public and the dental profession are concerned about the safety of dental treatment and any potential health risks that might be associated with the materials used to restore the teeth. All materials commonly used (and listed in this fact sheet) have been shown – through laboratory and clinical research, as well as through extensive clinical use – to be safe and effective for the general population. The presence of these materials in the teeth does not cause adverse health problems for the majority of the population. There exist a diversity of various scientific opinions regarding the safety of mercury dental amalgams. The research literature in peer-reviewed scientific journals suggests that otherwise healthy women, children and diabetics are not at increased risk for exposure to mercury from dental amalgams. Although there are various opinions with regard to mercury risk in pregnancy, diabetes, and children, these opinions are not scientifically conclusive and therefore the dentist may want to discuss these opinions with their patients. There is no research evidence that suggests pregnant women, diabetics and children are at increased health risk from dental amalgam fillings in their mouth. A recent study reported in the JADA factors in a reduced tolerance (1/50th of the WHO safe limit) for exposure in calculating the amount of mercury that might be taken in from dental fillings. This level falls below the established safe limits for exposure to a low concentration of mercury or any other released component from a dental restorative material. Thus, while these sub-populations may be perceived to be at increased health risk from exposure to dental restorative materials, the scientific evidence does not support that claim. However, there are individuals who may be susceptible to sensitivity, allergic or adverse reactions to selected materials. As with all dental materials, the risks and benefits should be discussed with the patient, especially with those in susceptible populations.

There are differences between dental materials and the individual elements or components that compose these materials. For example, dental amalgam filling material is composed mainly of mercury (43-54%) and varying percentages of silver, tin, and copper (46-57%). It should be noted that elemental mercury is listed on the Proposition 65 list of known toxins and carcinogens. Like all materials in our environment, each of these elements by themselves is toxic at some level of concentration if they are taken into the body. When they are mixed together, they react

chemically to form a crystalline metal alloy. Small amounts of free mercury may be released from amalgam fillings over time and can be detected in bodily fluids and expired air. The important question is whether any free mercury is present in sufficient levels to pose a health risk. Toxicity of any substance is related to dose, and doses of mercury or any other element that may be released from dental amalgam fillings falls far below the established safe levels as stated in the 1999 US Health and Human Service Toxicological Profile for Mercury Update.

All dental restorative materials (as well as all materials that we come in contact with in our daily life) have the potential to elicit allergic reactions in hypersensitive individuals.[1] These must be assessed on a case-by case basis, and susceptible individuals should avoid contact with allergenic materials. Documented reports of allergic reactions to dental amalgam exist (usually manifested by transient skin rashes in individuals who have come into contact with the material), but they are atypical. Documented reports of toxicity to dental amalgam exist, but they are rare. There have been anecdotal reports of toxicity to dental amalgam and as with all dental material risks and benefits of dental amalgam should be discussed with the patient, especially with those in susceptible populations.

Composite resins are the preferred alternative to amalgam in many cases. They have a long history of biocompatibility and safety. Composite resins are composed of a variety of complex inorganic and organic compounds, any of which might provoke allergic response in susceptible individuals. Reports of such sensitivity are atypical. However, there are individuals who may be susceptible to sensitivity, allergic or adverse reactions to composite resin restorations. The risks and benefits of all dental materials should be discussed with the patient, especially with those in susceptible populations.

Other dental materials that have elicited significant concern among dentists are nickel-chromium-beryllium alloys used predominantly for crowns and bridges. Approximately 10% of the female population are alleged to be allergic to nickel.[2] The incidence of allergic response to dental restorations made from nickel alloys is surprisingly rare. However, when a patient has a positive history of confirmed nickel allergy, or when such hypersensitivity to dental restorations is suspected, alternative metal alloys may be used. Discussion with the patient of the risks and benefits of these materials is indicated.

---

[1] Dental Amalgam: A scientific review and recommended public health service strategy for research, education and regulation, Dept. of Health and Human Services, Public Health Service, January 1993.

[2] Merck Index 1983. Tenth Edition, M Narsha Windhol z, (ed).

Patient Acknowledgement Form
Receipt of Dental Materials Fact Sheet

- ❑ My dentist has given me a copy of The Dental Board of California's Dental Materials Fact Sheet.

- ❑ My dentist has explained the reasons for recommending a specific type of dental restoration material.

- ❑ If I am pregnant, a diabetic, or a child (or guardian of a child patient), I have discussed the pros and cons of amalgam restoration with my dentist.

- ❑ If I have unusually sensitive reactions to other materials in the past, I have discussed the sensitivity with my dentist prior to restoration work.

- ❑ I have had a chance to ask any questions I may have, and have received satisfactory answers to those questions.

- ❑ Additional comments: _____

Signature: _____

Date: _____

Informed Refusal of Necessary X-Rays

Brian R. Sheaff, DDS
1945 Parkside Drive
Concord, CA 94519
(925)689-3450

Patient Name: _____
Date: _____

Dr. **Brian Sheaff**, has advised me to have necessary X-Rays for the accurate diagnosis and treatment of possible dental conditions in my mouth. The doctor and/or staff have explained the importance of using the diagnostic tool and have discussed with me the potential risks of not having recommended X-Rays on my oral health.

Having been informed, I elect not to have dental X-Rays at this time. I release the doctor and staff members from any responsibility resulting from refusal.

_____
Patient or Parent Signature (if under 18)

_____
Dentist or Staff Member Signature