First Step Dental

The First Choice for Your Child

Orthodontic treatment for children, teens & parents too!

TURLOCK 1729 N. Olive, Ste. 1 (209) 632-8400
MERCED 155 El Portal Dr., Ste. A (209) 720-2700

Welcome to our practice!

Patient's Name: ____________________ Preferred Name: ____________

Today's Date: ____/____/______ Birthdate: ____/____/______ Age:______Sex: Male / Female

Home Address: ____________________ City, State and Zip Code: ____________

How long at this address? ______Mailing address same as above? Y / N If no, please specify: ____________

Social Security No:____________ Email Address: ____________________

Home Phone: (____)____________ Cell Phone: (____)____________ Work: (____) ____________

Brothers/Sisters or Sons/Daughters (names & ages): ____________________

Whom may we thank for referring you to our office?____________________

Responsible Party Information

Name: ____________________ Relationship to Patient: ____________

Address: ____________________ City, State and Zip Code: ____________

Home Phone: (____)____________ Cell Phone: (____)____________ Email: ____________

Birthdate: ____/____/______ Social Security No: ____________ Driver's Lic. No.: ____________

Employed By: ____________________ For how long? ______ Occupation:____________

Interests: ____________ Marital Status: Single / Married / Separated / Widowed / Divorced

Does the primary responsible party have orthodontic insurance Yes / No **If yes, please complete insurance portion**

Spouse's Name/Secondary Responsible: ____________ Relationship to Patient: ____________

Address: ____________________ City, State and Zip Code: ____________

Home Phone: (____)____________ Cell Phone: (____)____________ Email: ____________

Birthdate: ____/____/______ Social Security No: ____________ Driver's Lic. No.: ____________

Employed By: ____________________ For how long? ______ Occupation:____________

Does the primary responsible party have orthodontic insurance Yes / No **If yes, please complete insurance portion**

Dental Insurance Information

Insured's Name: ____________________ Social Security: ____________

Insurance Company: ____________________ Group No.:____________

Insurance Co. Address: ____________________ Phone No.: (____) ____________

Insured's Employer: ____________ Employer Address, City & Zip: ____________

Is this the primary insurance for the patient? Yes / No *If there is dual coverage, please complete secondary info**

****SECONDARY**** Insured's Name: ____________ Social Security: ____________

Insurance Company: ____________________ Group No.:____________

Insurance Co. Address: ____________________ Phone No.: (____) ____________

Insured's Employer: ____________ Employer Address, City & Zip: ____________

Emergency Contact

Name of nearest relative not living with you: ____________ Phone: (____)____________

Address, City, State and Zip Code: ____________________ Relationship to Patient:____________

Medical History

Physician Name: ______________________ Date of Last Visit: ______________

Address: ______________________ Phone No.: (____) ______________

Please check Yes or No for the questions below. If yes, please fill in details: ______________

- O Yes O No Are you taking any medications? ______________
- O Yes O No Are you allergic to any medications? ______________
- O Yes O No Do you have a history of a major illness? ______________
- O Yes O No Have you had any operations? ______________
- O Yes O No Have you ever been involved in a serious accident? ______________
- O Yes O No Have you ever smoked or chewed tobacco? ______________
- O Yes O No Have you seen a physician in the last 12 months? If yes, why? ______________

____

For female patients:

- O Yes O No Are you pregnant?
- O Yes O No Has menstruation started?

Circle any of the medical conditions below that you have had or currently have:

Abnormal Bleeding/Hemophilia	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemo
Asthma/Hay Fever	Gastrointestinal Problems	HIV/AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Dental History

General Dentist: ______________ Date of Last Visit: ______________ Phone: (____) ______________

****Please tell us what concerns you most about your teeth:** ______________

- O Yes O No Are you presently in any dental plan?
- O Yes O No Have your wisdom teeth been removed?
- O Yes O No Have you ever lost or chipped any teeth?
- O Yes O No Have there been any injuries to face, mouth or teeth?
- O Yes O No Is any part of your mouth sensitive to temperature? If so, where? ______________
- O Yes O No Is any par of your mouth sensitive to pressure? If so, where? ______________
- O Yes O No Do you gums bleed when you brush?
- O Yes O No Have you ever experienced any unfavorable reaction to dentistry? Is so, what? ______________
- O Yes O No Do you have any type of thumb or tongue habit?
- O Yes O No Are you a mouth breather?
- O Yes O No Do your teeth or jaws ever feel uncomfortable when you wake in morning?
- O Yes O No Are you aware of your jaw clicking or popping?
- O Yes O No Are you aware of clenching your teeth during the day?
- O Yes O No Have you ever been told that you grind your teeth?
- O Yes O No Do you have "tension" headaches?
- O Yes O No Have you ever experienced chronic ringing in you ears?
- O Yes O No Have you ever seen an orthodontist? If yes, who and when? ______________
  What is your attitude toward receiving orthodontic treatment? ______________
- O Yes O No Has anyone in your family received orthodontic treatment? If so, who? ______________
  How did they feel about the results? ______________
- O Yes O No Are you aware that some appointments will be during work/school hours?

Benefits of Orthodontics: Aesthetics, Health and Function. It is a service that provides improvement in the appearance of teeth, in the general function of the teeth and in general dental health. Teeth, gums and jaws are an intricate body party and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth can change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational purposes. I have truthfully answered all of the above questions and agree to inform First Step Dental's office of any changes in my medical or dental history. In addition, I authorize First Step Dental to perform a complete orthodontic evaluation.

Signature: ______________________ Date: ______________

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Bienvenidos a Nuestra Officina!

Nombre de Paciente: ____ Nombre Preferido: ______________________
Fecha de Hoy: ___/____/____ Fecha de Nacimiento: ___/____/____ Edad:______Genero: Masculino/Femenina
Domicilio: _____________________________________ Ciudad/ Estado/ Codigo Postal: _______________________
Cuanto Tiempo en Esta Domicilio?: ______Direccion Postal es Igual? Si No Especifica: ______________________
Numero de Seguro Social:______________________ Correo Electronico: ___________________________________
Numero de Telefono de Casa: (___)___________ De Cellular: (___)_____________ De Trabajo: (___) __________
Hermanos/ Hermanas o Hijos/Hijas (Nombres y Edades): ____
Escuela y Grado: _________________________________ Intereses/ Aficiones: _______________________________
A Quien Podemos Agradecer por Referido a Nuesta Oficina? ____

Informacion del Persona Responsable

Nombre de Padre: _____________________________ Estado Civil: Soltero / Casado/ Separado/ Viudo/ Divorciado
Domicilio: _______________________________________ Ciudad/ Estado/ Codigo Postal: _____________________
Numero de Telefono de Casa: (___)___________ De Cellular: (___)_____________ De Trabajo: _______________
Fecha de Nacimiento: ____/____/____ Num. de Seguro Social: ________________ Num. de Licencia:___________
Empleador: _________________________________ Cuanto Tiempo? _______ Ocupacion: _____________________
La Segura Dental Tiene Cobertura Ortodoncia?: Si/ No **Si Tiene, Por Favor Complete la Parte de el Seguro**

Nombre de Madre: ____________________________ Estado Civil: Soltera / Casada/ Separada/ Viuda/ Divorciada
Domicilio: _______________________________________ Ciudad/ Estado/ Codigo Postal: _____________________
Numero de Telefono de Casa: (___)__________ De Cellular: (___)___________ Correo Electronico: ___________
Fecha de Nacimiento: ____/____/____ Num. de Seguro Social: ________________ Num. de Licencia:___________
Empleador: _________________________________ Cuanto Tiempo? _______ Ocupacion: _____________________
La Segura Dental Tiene Cobertura Ortodoncia?: Si/ No **Si Tiene, Por Favor Complete la Parte de el Seguro**

Dental Insurance Information

Nombre del Asegurado: _____________________________________ Numero de Seguro Social: ________________
Compañia de Seguro: ____ Numero de Grupo: _____________________
Domicilio de la Seguro: ______________________________________ Numero de Telefono: (____) _____________
Empleador del Asegurado: __________________ Direccion/ Ciudad/ Codigo Postal: _________________________
Es Este el Seguro Dental Primaria? Si / No *Si Hay Doble Cobertura, Por Favor Complete la Informacion Secundaria**

Informacion de Seguro Secundaria

Nombre del Asegurado: _____________________________________ Numero de Seguro Social: ________________
Compañia de Seguro: ____ Numero de Grupo: _____________________
Domicilio de la Seguro: ______________________________________ Numero de Telefono: (____) _____________
Empleador del Asegurado: __________________ Direccion/ Ciudad/ Codigo Postal: _________________________

Informacion de Contacto de Emergencia

Nombre de Pariente Mas Acercado que no Vive con Usted: ____
Numero de Telefono: (____)____________________________Relacion Con el Paciente: ________________________
Direccion/ Ciudad/ Estedo y Codigo Postal: ____

Menor/ Asegurado Dependiente

Historia Medica

Nombre del Medico: ______________________________ Fecha de la Ultima Visita: ______________

Direccion: ______________________________ Numero de Telefono: (____) ______________

Por Favor, Marque Si o No a las Siguientes Preguntas. So Respode Si, Por Favor Llene Los Tetalles:

- O Si O No Esta Tomando Algun Medicamento? ______________
- O Si O No Es Alergico a Algun Medicamento? ______________
- O Si O No Tiene Historia de Enfermedad Grave? ______________
- O Si O No Ha Tenido Alguna Operacion? ______________
- O Si O No Ha Estado Alguna Vez Involucrado en un Accidente Grave? ______________
- O Si O No Alguna Vez Ha Fumado o Masticado Tabaco? ______________
- O Si O No Has Visto a un Medico en los Ultimos 12 Meses? Si es Si Por Que?______________

____

For female patients:

- O Si O No Estas Embarazada?
- O Si O No Ha Comenzado la Menstruacion?

Circule Cualquiera de las Siguientes Condiciones que Usted ha Tenido o que Actualmente Tienen:

Sangrado Anormal/ Hemofilia	Diabetes	Hepatitis/ Problema del Higado	Anemia
Mareo	Herpes	Artritis	Epilepsia
Presion Alta Sangulnea	Asma/ Fiebre de Heno	Problemas Gastrointestinales	VIH/SIDA
Trastornos de los Huesos	Problemas del Corazon	Problemas de Riñon	Soplo Cardiaco
Defecto Congenito de Corazon	Trastorno Nervioso	Neumonia	Sangramiento Prolongado
Radiacion/ Quimioterapia	Fiebre Reumatica	Tuberculosis	Tumor o Cancer

Historia Dental

Dentista General: ______________ Fecha de Ultima Visita: ______________ Telefono (____) ______________

****Por Favor, Diganos que mas se Preocupa Acerca de sus Dientes:** ______________

- O Si O No Esta Usted en Dolor de un Diente?
- O Si O No Se han Quitado las Muelas del Juicio?
- O Si O No Alguna vez has perdido o astillado algun diente?
- O Si O No Ha Tenido una Herida en la Cara, la Boca o los Dientes?
- O Si O No Hay Alguna Parte de tu Boca Sensible a la Temperatura? Si es Adi, donde? ______________
- O Si O No Hay Alguna Parte de tu Boca Sensible a la Temperatura? Si es Adi, donde? ______________
- O Si O No Sus Encias Sangran al Cepillarse?
- O Si O No Has Experimentado Alguna Reaccion Desfavorable en la Dentista? Si es asi, en que?______________
- O Si O No Tienes Algun Tipo de Habito de un Pulgar or Lengua?
- O Yes O No Esta Usted Usando una Respiro de Boca?
- O Yes O No Sus Dientes o Mandibula se Sienten Incomodos Cuando te Levantas por la Mañana?
- O Yes O No Eres Consciente de que tu Mandibula Reproduce Click o Estallidos?
- O Yes O No Eres Consciente de Apretar los Dientes durante el Dia?
- O Yes O No Te han Dicho Aluna Vez que Usted se Rechina los Dientes?
- O Yes O No Tiene Usted Dolores de Cabeza Tensionales?
- O Yes O No Alguna Vez has Experimentado Zumbido Cronica en le Oido?
- O Yes O No Has Ido a una Ortodoncista? Si es Asi, Quien y Cuando? ______________
  Que es su Actitud Hacia Recibir Tratamiento de Ortodoncia? ______________
- O Yes O No Alguien en su Familia han Recibido Tratamiento de Ortodoncia? Si es Asi, Quien? ______________
- O Yes O No Esta Usted Conciente de que Algunas Citas Seran Durantes las horas de Escuela/ Trabajo?

Beneficios de Ortodoncia: Estetica, Salud, y Funcion. Es un servicio que mejora la apariencia de los dientes, la funcion general, y tambien en la salud dental general. Los dientes, encias, y mandibulas, estan en un parte del cuerpo intricado y pueden fallar en responder al tratamiento. Si la higiene oral buena no esta practicado, la caries dental encias imflamadas pueden resultar. Molestias en las articulaciones y el acortamiento de la raiz del diente se han observado en un pequeño porcentaje de casos. Los dientes pueden cambiar a lo largo de nuestra vida y puede haber algo de movimiento de los dientes y puede resultar en un cambio despues del tratamiento. He leido y entendido este parrafo. Tambien entiendo que mi nombre y expedientes de diagnostico se pueden utilizar con el propositos de educar. He contestado con sinceridad a todos las preguntas anteriores y estoy de acuerdo a informar a First Step Dental de cualquier cambio qe hayga en mi historia medico o dental. Adicionalmente, yo autorizo a First Step Dental a realizar una evalucion de ortodoncia completa.

Firma: ______________________________ Fecha: ______________________________

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Welcome to our practice!

Patient's Name: ____________________ Preferred Name: ____________

Today's Date: ____/____/____ Birthdate: ____/____/____ Age:______Sex: Male / Female

Home Address: ____________________ City, State and Zip Code: ____________

How long at this address? ______Mailing address same as above? Y / N If no, please specify: ____________

Social Security No:____________ Email Address: ____________________

Home Phone: (____)__________ Cell Phone: (____)__________ Work: (____) __________

Brothers/Sisters or Sons/Daughters (names & ages): ____________________

Whom may we thank for referring you to our office?____________________

Responsible Party Information

Name: ____________________ Relationship to Patient: ____________

Address: ____________________ City, State and Zip Code: ____________

Home Phone: (____)__________ Cell Phone: (____)__________ Email: ____________

Birthdate: ____/____/____ Social Security No: __________ Driver's Lic. No.: __________

Employed By: ____________________ For how long? ______ Occupation:__________

Interests: ______________ Marital Status: Single / Married / Separated / Widowed / Divorced

Does the primary responsible party have orthodontic insurance Yes / No **If yes, please complete insurance portion**

Spouse's Name/Secondary Responsible: ______________ Relationship to Patient: __________

Address: ____________________ City, State and Zip Code: ____________

Home Phone: (____)__________ Cell Phone: (____)__________ Email: ____________

Birthdate: ____/____/____ Social Security No: __________ Driver's Lic. No.: __________

Employed By: ____________________ For how long? ______ Occupation:__________

Does the primary responsible party have orthodontic insurance Yes / No **If yes, please complete insurance portion**

Dental Insurance Information

Insured's Name: ____________________ Social Security: ____________

Insurance Company: ____________________ Group No.:____________

Insurance Co. Address: ____________________ Phone No.: (____) __________

Insured's Employer: ______________ Employer Address, City & Zip: ____________

Is this the primary insurance for the patient? Yes / No *If there is dual coverage, please complete secondary info**

****SECONDARY**** Insured's Name: ______________ Social Security: ____________

Insurance Company: ____________________ Group No.:____________

Insurance Co. Address: ____________________ Phone No.: (____) __________

Insured's Employer: ______________ Employer Address, City & Zip: ____________

Emergency Contact

Name of nearest relative not living with you: ______________ Phone: (____)__________

Address, City, State and Zip Code: ______________ Relationship to Patient:__________

MINOR / INSURED DEPENDENT

Medical History

Physician Name: ______________________________ Date of Last Visit: ________________

Address: ______________________________ Phone No.: (____) ________________

Please check Yes or No for the questions below. If yes, please fill in details: ______________________

- O Yes O No Are you taking any medications? ______________________
- O Yes O No Are you allergic to any medications? ______________________
- O Yes O No Do you have a history of a major illness? ______________________
- O Yes O No Have you had any operations? ______________________
- O Yes O No Have you ever been involved in a serious accident? ______________________
- O Yes O No Have you ever smoked or chewed tobacco? ______________________
- O Yes O No Have you seen a physician in the last 12 months? If yes, why? ______________________

____

For female patients:

- O Yes O No Are you pregnant?
- O Yes O No Has menstruation started?

Circle any of the medical conditions below that you have had or currently have:

Abnormal Bleeding/Hemophilia	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemo
Asthma/Hay Fever	Gastrointestinal Problems	HIV/AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Any other health concerns that you would like to discuss? ______________________

Dental History

General Dentist: ________________ Date of Last Visit: ____________ Phone: (____) __________

****Please tell us what concerns you most about your teeth:** ______________________

- O Yes O No Are you presently in any dental plan?
- O Yes O No Have your wisdom teeth been removed?
- O Yes O No Have you ever lost or chipped any teeth?
- O Yes O No Have there been any injuries to face, mouth or teeth?
- O Yes O No Is any part of your mouth sensitive to temperature? If so, where? ________________
- O Yes O No Is any par of your mouth sensitive to pressure? If so, where? ________________
- O Yes O No Do you gums bleed when you brush?
- O Yes O No Have you ever experienced any unfavorable reaction to dentistry? Is so, what? __________
- O Yes O No Do you have any type of thumb or tongue habit?
- O Yes O No Are you a mouth breather?
- O Yes O No Do your teeth or jaws ever feel uncomfortable when you wake in morning?
- O Yes O No Are you aware of your jaw clicking or popping?
- O Yes O No Are you aware of clenching your teeth during the day?
- O Yes O No Have you ever been told that you grind your teeth?
- O Yes O No Do you have “tension” headaches?
- O Yes O No Have you ever experienced chronic ringing in you ears?
- O Yes O No Have you ever seen an orthodontist? If yes, who and when? ________________

  What is your attitude toward receiving orthodontic treatment? ________________
- O Yes O No Has anyone in your family received orthodontic treatment? If so, who? ________________

  How did they feel about the results? ________________
- O Yes O No Are you aware that some appointments will be during work/school hours?

Benefits of Orthodontics: Aesthetics, Health and Function. It is a service that provides improvement in the appearance of teeth, in the general function of the teeth and in general dental health. Teeth, gums and jaws are an intricate body party and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth can change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational purposes. I have truthfully answered all of the above questions and agree to inform First Step Dental’s office of any changes in my medical or dental history. In addition, I authorize First Step Dental to perform a complete orthodontic evaluation.

Signature: ______________________________ Date: ______________________

California Dental Association
1201 K Street, Sacramento, CA 95814
800.232.7645 cda.org

Notice of Privacy Practices

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

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect September 23, 2013 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 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 make the new notice available upon request. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

Uses and Disclosures of Health Information

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

Treatment
We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment
We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations
We may use and disclose your health information in connection with our health care operations, for example in sending appointment reminders. Other health care operations include but are not limited to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. The California Confidentiality of Medical Information Act does limit the types of health care operations in which we can use or disclose your health information without your authorization. For example, if the dental practice is sold or merged, the new owner will seek permission to use your information to continue to treat you. Your authorization also is required if a credit or collection agency seeks your health information. We may use business associates to conduct the above transactions. We may also use and disclose your health information if required by law or for public health, benefit and safety purposes. For example:

Public Health and Safety
We may disclose your health information to a public health authority as part of lawful activities to prevent or control disease, injuries and disabilities and to the U.S. Food and Drug Administration to report safety issues with drugs and medical devices. We may disclose your health information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Government Oversight
We may disclose your health information to government regulatory agencies, such as the Dental Board of California or the U.S. Department of Health and Human Services, to carry out their legal responsibilities in investigations, inspections, audits, enforcement and licensing.

Law Enforcement, Coroners and Legal Proceedings
We may disclose your health information to a law enforcement agency, coroner or medical examiner for official purposes such as identifying an individual or reporting crimes. We may be compelled to disclose your health information in response to a subpoena, court order, discovery request or other legal process. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Workers' Compensation
We may disclose your health information to the extent permitted for workers' compensation.

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National Security
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence and other national security activities.

Your Authorization
You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted uses described in this notice.
We may request your authorization to use your name, image or testimonial in our social media platforms and marketing efforts. We may request your authorization to release your insurance information to another healthcare provider.

Other Uses and Disclosures of Health Information

We may use and disclose your health information in the following circumstances:

To Family, Friends and Persons Involved in Your Care
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 your 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 health care. 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, aligners, X-rays or other similar forms of health information.

You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

Marketing Health-Related Services
We may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. Your information will be used to notify you of the change and the new owner may seek to obtain your permission to use your information to continue to treat you. You may request that copies of your health information be transferred to another dental practice.

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Research
Your health information may be disclosed to researchers for research purposes. In this situation, written authorization is not required if approved by an Institutional Review Board or privacy board.

Fundraising
We may use or disclose demographic information and dates of treatment in order to contact you for fundraising activities. If you no longer wish to receive these communications, notify us at the contact information provided below and we will stop sending further fundraising information.

Patient Rights

Access
You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. California law requires you be provided with access to your health information within 15 days. Contact us for a full explanation of our fee structure.

Disclosure Accounting
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. 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 health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication
You have the right to request that we communicate with you about your health information by alternative means or to send it to an alternative location. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payment for treatment will be handled under the alternative means or location you request.

Breach Notification
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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.

Notice of Privacy Practices
You have the right to a paper copy of this notice at any time.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at:

1729 N. Olive Ave. Ste. 15 Turlock, CA 95382
Office: 209-669-8120 Fax: 209-669-8123

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

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health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

We comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,______________________________ [full name], have received a copy of the First Step Dental Notice of Privacy Practices.

Print Name ____

Signature ____

Date ____

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

Personal Representative's name ____

Relationship to Patient ____

For Program Use Only

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

- ▫ Individual refused to sign
- ▫ Communications barriers prohibited obtaining the acknowledgement
- ▫ An emergency situation prevented us from obtaining acknowledgement
- ▫ Other (Please Specify)