CONFIDENTIAL HEALTH HISTORY

Patient Name:_____ Date of Birth: _____

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

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

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

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

Other: _____

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

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes Type I	Yes / No Asthma
Type/ Date of surgery: _____	Yes / No Diabetes Type II	Yes / No Eczema
_____	Yes / No Psoriasis	Yes / No Anxiety
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexually transmitted
Yes / No Pacemaker	Type?_____	disease
Date implanted: _____	Yes / No Osteopenia	
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes(Cold Sore)
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker sores
Yes / No Skin disease	Yes / No Arthritis/ rheumatism	Yes / No Anemia
Yes / No Atherosclerosis	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other:_____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Valium or sedatives	Yes / No Codeine or other opioids
Yes / No Penicillin or other antibiotics	Yes / No Latex	Yes / No Food
Yes / No Nitrous oxide	Yes / No Local anesthetic	Yes / No Metal

Others: _____

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

(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Antidepressants	Yes / No	Herbal supplements		

Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: _____

Please list all prescription medications: _____

_____

_____

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

Yes / No Are you or could you be pregnant? If YES, how many months? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

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

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain: _____

_____

Yes / No Have you ever had to take an antibiotic prior to dental treatment? If YES, why: _____

Yes / No Have you tested positive for COVID-19?

If YES, date of positive test result: _____

Yes / No Are you experiencing any ongoing or lasting symptoms or effects as a result?

If YES, what are these symptoms or effects? _____

Yes / No Are you currently under the care of a physician or taking any medications for any of the conditions listed above?

If YES, please list _____

If patient answers ''yes'' to any of the questions above, consider seeking additional information from the patient regarding their symptoms and medications, prior to treatment.

Yes / No **Are there any issues or conditions that you would like to discuss with the dentist in private?**

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

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

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

Name: _____ **Relationship:** _____ **Phone Number:** _____

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

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

Dental Health History Form

Today's Date _____

Patient Name: First _____ MI ___ Last _____ Nickname _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past? _____

Date of last radiographs (x-rays) and exam _____

Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)* _____

Former Dentist _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? ☐ Yes ☐ No

If yes, please describe _____

Have you ever been pre-medicated for dental treatment? ☐ Yes ☐ No

If yes, why? _____

Have you been anxious about having dental treatment? ☐ Yes ☐ No

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? _____

What concerns do you currently have with your oral health or smile? *(check all that apply)*

☐ Jaw joint pain
☐ Clenching or grinding of teeth
☐ Discolored teeth
☐ Crowding/Crooked teeth
☐ Missing teeth
☐ Spaces in between teeth
☐ Loose tooth/teeth
☐ Tooth shape or size
☐ Unhappy with appearance of teeth
☐ Overbite
☐ Underbite
☐ Uncomfortable bite
☐ Old fillings *(gold or silver)*
☐ Old crowns
☐ Speech problems
☐ Too much gum tissue when I smile
☐ Tooth sensitivity to hot/cold or anything else
☐ Food gets caught in between teeth
If yes, where? _____
☐ Difficulty chewing
If yes, where? _____
☐ Bad breath
☐ Other _____

Have you ever had orthodontic treatment? ☐ Yes ☐ No

If yes, when? _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery? ☐ Yes ☐ No

If yes, when? _____

Have you whitened your teeth in the past? ☐ Yes ☐ No

If yes, what method? _____

Are you interested in learning more about the following? *(check all that apply)*

☐ Teeth Whitening
☐ Orthodontic treatment
☐ Veneers
☐ Tooth-colored fillings
☐ Dental implants
☐ How to prevent periodontal disease
☐ At-home oral hygiene care
☐ Periodontal treatment during pregnancy
☐ Oral hygiene care for infants and toddlers

Patient Information Form

Today's Date _____

Patient Name: First _____ MI ____ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-mail address _____

By Providing your e-mail address you agree to receive *(check one or both)* ☐ Appointment Reminders ☐ Practice Newsletter

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Social Security Number _____ **Date of Birth** _____

Drivers License # _____ **State** _____

Patient Employed By _____ **Occupation** _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ **Home Phone** _____ **Mobile Phone** _____

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School** _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Employer *(if different from above)* _____ **Occupation** _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____

Secondary Dental Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____

Whom may we thank for referring you?

☐ One of our valued patients *(name of patient)*

☐ Advertisement_____ ☐ Local Dental Society

☐ Our Web site ☐ Other

Please list other members of your immediate family who are patients in our practice

_____ _____ _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment Cash, check, Visa, MasterCard, Discover or CareCredit.
***** *Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 24-hour notice to reschedule an appointment. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. If short notice (24 hr) cancellations become habitual a patient may be required to schedule "same day" appointments by calling in the day they are available. If our schedule permits the appointment will be made for that patient.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment._____(initial)

I have read the above and agree to the financial and scheduling terms._____(initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. _____(initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice._____(initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet._____(initial)

Signature(Parent if minor)_____Date _____

James P. Zimmerman, D.D.S., F.A.G.D.

Your Information. Your Rights. Our Responsibilities.

This notice of our privacy practices describes how your protected health information may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective date: **02/16/2026**

Your Rights	**You have the right to:** • Get a copy of your record. • Correct information in your record. • Request confidential communication. • Ask us to limit the information we share. • Get a list of those with whom we have shared your information. • Get a copy of this privacy notice. • Choose someone to act for you. • File a complaint if you believe your privacy rights have been violated.
Your Choices	**You have some choices in the way that we use and share information as we:** • Tell family and friends about your condition. • Provide disaster relief. • Market our services and sell your information. • Raise funds (delete if your practice is not a nonprofit clinic).
Our Uses and Disclosures	**We may use and share your information as we:** • Treat you. requests. • Run our organization. • Bill for your services. • Help with public health and safety issues. • Do research. • Comply with the law. • Respond to organ and tissue donation • Work with a medical examiner or funeral director. • Address workers' compensation, law enforcement, and other government requests. • Respond to lawsuits and legal actions.

James P. Zimmerman, D.D.S., F.A.G.D. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

English: Our dental practice will provide language assistance services free-of-charge to individuals who do not speak English well enough to discuss the dental care we are providing.

Spanish: Nuestro consultorio dental les proporcionará servicios de asistencia lingüística gratuitos a los individuos que no hablen inglés con suficiente fluidez para discutir la atención dental que proporcionamos.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your record

- You can ask to see or get an electronic or paper copy of your record. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will verify the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information below.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information, except as part of a practice sale or merger.
- Substance use disorder treatment information in your record.

In the case of fundraising for our nonprofit organization, we may contact you for fundraising efforts, but you can tell us not to contact you again. (Delete if statement is not applicable.)

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you We can use your health information and share it with other professionals who are treating you. The dentist may refer you to another dentist who specializes in treating certain types of cases, or may consult with your physician when you are scheduled for dental surgery.

Run our organization We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we may use a third-party service or artificial intelligence system to manage appointment reminders, patient communications and our schedule, and to assist with documentation. When we do so, we have agreements that reinforce that they are required to comply with privacy and security laws.

Bill for your services We can use and share your health information to bill and get payment from health plans or other entities. Example: We give necessary information about you to your health insurance plan so it will pay for the services we provide you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet specified conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.

- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

Do research We can use or share your information for health research.

Comply with the law We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Work with a medical examiner or funeral director We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military and national security.

Respond to lawsuits and legal actions We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will not send you unsecured emails containing your protected health information without obtaining your informed consent.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We are required to comply with California law which places further restrictions on the use and disclosure of your information. For example, we may not share without your written consent any information we hold regarding treatment for mental health or substance abuse, abortion, contraception or gender-affirming care.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our web site.

Other Instructions for Notice

- *Insert any special notes that apply to your entity's practices such as "we never market or sell personal information."*
- *If your dental practice is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."*

Questions and Complaints

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

Privacy Officer: **Lisa Jimenez, RDAEF2 Office Manager**

Telephone: **530-661-1155**

Email: **lisa@mywoodlanddentist.com**

Address: **127 Court St. Woodland, CA 95695**

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/ complaints/. We will not retaliate against you for filing a complaint.

James P. Zimmerman, D.D.S., F.A.G.D. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

CALIFORNIA

English:
Our dental practice will provide language assistance services free-of-charge to individuals who do not speak English well enough to discuss the dental care we are providing.

Spanish:
Nuestro consultorio dental les proporcionará servicios de asistencia lingüística gratuitos a los individuos que no hablen inglés con suficiente fluidez para discutir la atención dental que proporcionamos.

Chinese:
我们的牙科业务将为英语不太流利的人士提供免费的语言协助服务，以方便讨论我们提供的牙齿护理服务。

Vietnamese:
Thực hành nha khoa của chúng tôi sẽ cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí cho những người không có khả năng nói tiếng Anh đủ tốt để thảo luận việc chăm sóc răng miệng mà chúng tôi đang cung cấp.

Tagalog:
Ang aming dental na kasanayan ay magbibigay ng walang bayad na mga serbisyong tulong na wika sa mga indibidwal na hindi nakakapagsalita ng maayos na Ingles upang talakayin ang ibinibigay naming dental na pangangalaga.

Korean:
저희 치과는 저희가 제공하는 치과 치료에 대해 영어로 논의하기가 불편하신 분들을 위해 무료 언어 지원 서비스를 제공할 것입니다.

Armenian:
Մեր ատամնաբուժական պրակտիկան կտրամադրի անվճար լեզվական ծառայություններ բոլոր
այն անձանց ովքեր անգլերենին բավարար չեն տիրապետում մեր կողմից տրամադրվող
ատամնաբուժական խնամքի շուրջ հարցեր քննարկելու:

Persian (Farsi):
رمکز خدمات دندانپزشکیماخدمات کمک زبانی را به صورت را ان ای افرادی فراهمیآ دکهانگلیسی را با تسلط صحبت نمیکند تا در مورد مراقبت های د انی که ارائهٔ میکـ یم گفتگو کنند.

Russian:
Наша стоматологическая клиника бесплатно предоставляет клиентам, которые не достаточно хорошо говорят на английском языке, услуги переводчика, чтобы помочь им обсудить предоставляемую нами стоматологическую помощь.

Japanese:
当社の歯科治療では提供している歯科ケアに関して話し合える程度の英語力のない方に無料で言語サポートサービスを提供してい

ま。

Arabic:
سوف تقدم عيادة طب الأسنان مساعدة لغوية مجانية لأولئك الذين لا يجيدون الإنكليزية من أجل مناقشة خدمات العناية بالأسنان التي نقد امه

Punjabi:
ਉਰ ਡ%ਟਲ ਪ)ੈਕਿਟਸ ਿਵਲ ਪੋ)ਵੀਦੇ ਲ%ਗੁਏਜ ਅੱਸੀਸਟ%ਸ ਸਰਿਵਸਜ਼ ਫ)ੀ-ਓਫ-ਚਾਰਜ ਤ@ ਇੰਿਡਿਵਦੁਲਸ ਹੁ ਦੋ ਨ ਸਪੈFਕ ਇੰਗਿਲਸ਼ ਵੈFਲ ਏਨੋਘ ਤ@ ਿਡਸਕਸ ਥੇ ਡ%ਟਲ ਚਾਰੇ ਵੀ ਰੇ

ਪ)ੋਵੀਡੀਨਗ.

Mon-Khmer:
គី" និកេធ)ញោយ,ងខ/ ំនឹងផ4ល់នូវេស-ជំនួយែផត?@ោAយឥតគិតៃថជូនដល់អតិថិជនH ក់ឮែដលមិនេចះនិMយ?@អង់ចNស់Oស់
េដUPីពិេRSះពិ?កTSអំពី បWេសតំែហYំេធ)ញ្ញេដលេយ,ងខ/0ំកំពុងផ4ល់ជូន។

Hmong:
Ang aming pagsasanay ukol sa ngipin o dental practice ay magbibigay ng libreng mga serbisyong tulong sa mga indibiduwal na hindi masyadong nakakapagsalita ng Ingles upang talakayin ang pangangalaga sa ngipin na aming ibinibigay.

Hindi:
हमारे दंत)च+क-छालय के 1भार3, जो 6य7ती अ-छ: तरह ;<ल3श बोल नह3 सकते है उनको, हम जो दंत)च+क-छा देखभाल 1दान कर रहे है उसके बारेमD बात करनेके Eलये बीना कोई फ़Hस भाषा सहायता सेवाएं 1दान करDगे |

Thai:
แนวปฏิบัติด้านทันตกรรมของเราจะให้บริการช่วยเหลือด้านภาษาฟรีแก่บุคคลทีDพูดภาษาอังกฤษไม่ชำนาญเพียงพอทีDจะหารือเกีDยวกับบริการทันตกรรมของเรา

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____ [full name], have received a copy of the **James P. Zimmerman, D.D.S., F.A.G.D.** 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)

DENTAL MATERIALS FACT SHEET

WHY YOU HAVE RECEIVED THIS FACT SHEET?

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 Business and Professions Code 1648.10-1648.20 to make this dental materials fact sheet available to every dentist in the state of California. The 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 guardian, you are strongly encouraged to discuss with your dentist the facts presents concerning the filling materials being considered for you particular treatment.

ALLERGIC REACTIONS TO DENTAL MATERIALS

Components in dental fillings may have side effects o 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 it's 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 (43-53%) and an alloy powder (46-57%) composed mainly of silver, tin, and copper. This has caused discussion about the risks of mercury in dental amalgam. Such mercury is emitted in minute amounts as vapor. Some concerns have been raised regarding possible toxicity. Scientific research continues on the safety of dental amalgam. According to the Centers for Disease Control and Prevention, there is scant evidence that the health of the vast majority of people with amalgam is compromised.

The food and Drug Administration (FDA) and other public health organizations have investigated the safety of amalgam used in dental fillings. The conclusion: no valid scientific evidence has shown that amalgams cause harm to patients with dental restorations, except in rare cases of allergy. The World Health Organization reached a similar conclusion stating, "Amalgam restorations are safe and cost effective."

A diversity of opinions exists regarding the safety of dental amalgams. Questions have been raised about its safety in pregnant women, children and diabetics. However, scientific evidence and research literature in peer-reviewed scientific journals suggest that otherwise healthy women, children, and diabetics are not at an increased risk form dental amalgam in their mouths. The FDA places no restriction 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

AMALGAM

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

Advantages	Disadvantages
• Durable; long lasting • Wears well; holds up well to the forces of biting • Relatively inexpensive • Generally completed in on 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	• Refer to "Why You Have Received this Fact Sheet" • Gray colored, not tooth colored • May darken as it corrodes; may stain teeth over time • Require 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 sensitivity to temperature. • Contact with other metals may cause occasional, minute electrical flow.

Composite Resin

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	Disadvantages
• 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 hold up well to the forces of biting depending on product used • Resistance to further decay is moderate and easy to find • Frequency of repair or replacement is low to moderate	• Refer to "Why You Have Received this Fact Sheet" • Moderate occurrence of tooth sensitivity; sensitive to dentist's method of application • Costs more than dental amalgam • Material shrinks when hardened and could lead to further decay and/or temperature sensitivity • Requires more than one visit for inlays, veneers and crowns • May wear faster than dental enamel • May leak over time when bonded beneath the layer of enamel

GLASS IONOMER

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	Disadvantages
• Reasonably good esthetics • May provide some help against decay because it releases fluoride • Minimal amount of tooth needs to be removed and it bonds will to both the enamel and the dentin beneath the enamel • Material has low incidence of producing tooth sensitivity • Usually completed in one dental visit	• Cost is 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 accumulation of plaque and chance of periodontal disease • Does not wear well; tends to crack over time and can be dislodged

The durability of any dental restoration is influence not only by the material is 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.

RESIN-IONOMER CEMENT

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

Advantages	Disadvantages
• Very good esthetics • May provide some help against decay because it releases fluoride • Minimal amount of tooth needs to be removed and it bonds to both 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	• Cost is very similar to composite resin (which costs more than amalgam) • Limited use because it is not recommended to restore the biting surface in adults • Wears faster than composite and amalgam

Porcelain (Ceramic)

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

Advantages	Disadvantages
• Very little tooth needs to be removed for use as a veneer; more tooth needs to be removed for a crown because its strength is related to its bulk (size) • Good resistance to further decay if the restoration fits well • It is resistant to surface wear but can cause some wear on opposing teeth • Resists leakage because it can be shaped for a very accurate fit • The material does not cause tooth sensitivity	• Material is brittle and can break under biting forces • May not be recommended for molar teeth • Higher cost because it requires at least two office visits and laboratory services

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

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

Porcelain Fused to Metal
This type of porcelain is a glass-like material tht is "enameled" on top of metal shells. It is tooth-colored and is used for crowns and bridges.

Advantages	Disadvantages
• Good resistance to further decay if the restoration fits well • Very durable, due to metal • The material does not cause tooth sensitivity • Resists leakage because it can be shaped for a very accurate fit	• 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
Gold alloy is a gold-colored mixture of gold, copper and other metals and is used mainly for crowns, fixed bridges and some partial denture frameworks.

Advantages	Disadvantages
• 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	• It 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 services