

Patient Name: _____ Birth Date: _____

Patient Address: _____ City: _____ State/Zip: _____

Patient Home Phone: _____ Patient Work Phone: _____ Patient Cell Phone: _____

Primary Physician's Name: _____ SS#: _____

Major dental problem or reason for coming: _____

Patients e-mail: _____ May we e-mail appointment reminders? Yes No

	YES	NO
Have you been instructed or have the need to be pre-medicated for any dental procedure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any artificial joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an unexplained gain or loss of weight (past 6 months)? How Much? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke or use tobacco? If yes, how much.	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated for cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had radiation treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you are currently more tired than usual?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any body aches and pains?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats or recurring fever?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever used intravenous drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you used cocaine or "crack" within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you actively engage in high risk behavior for infectious diseases (e.g. AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>

Medical Information

Do you have or have you ever had:

HEAD AND NECK	YES	NO
Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma/eye disease	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent earaches/hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinusitis/post-nasal discharge	<input type="checkbox"/>	<input type="checkbox"/>
Recently difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Persistent sore throat and hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Swollen neck glands	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent neckache or neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Injury to head,neck,jaw,teeth	<input type="checkbox"/>	<input type="checkbox"/>

DENTAL	YES	NO
Chronic face pain	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing jaw	<input type="checkbox"/>	<input type="checkbox"/>
Unable to chew food well	<input type="checkbox"/>	<input type="checkbox"/>
Blisters/sores on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you ever had:

NEUROMUSCULAR SYSTEM	YES	NO
Fainting spells or loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Numbness, tingling, or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent backaches	<input type="checkbox"/>	<input type="checkbox"/>
Problem/walking, balance, dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Persistent stiffness or painful joints	<input type="checkbox"/>	<input type="checkbox"/>
Artificial bone or joint implants	<input type="checkbox"/>	<input type="checkbox"/>
Recent or unusual headaches	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY	YES	NO
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or a persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughed up blood	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>

DENTAL (Cont'd)	YES	NO
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or infected gums	<input type="checkbox"/>	<input type="checkbox"/>
Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Pain when chewing or opening mouth	<input type="checkbox"/>	<input type="checkbox"/>
Catching of food between teeth	<input type="checkbox"/>	<input type="checkbox"/>
Recent toothache/sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Uncomfortable bite	<input type="checkbox"/>	<input type="checkbox"/>
Recent need to chew on one side	<input type="checkbox"/>	<input type="checkbox"/>
Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>
Your bite adjusted	<input type="checkbox"/>	<input type="checkbox"/>
Bite appliance (TMJ splint)	<input type="checkbox"/>	<input type="checkbox"/>
Gum treatment or surgery	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontic Treatment (braces)	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR	YES	NO
High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing upon swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing when sleeping without extra pillows	<input type="checkbox"/>	<input type="checkbox"/>
Irregular or rapid heart beats	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain due to physical exertion	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain when upset	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease or fever	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease/heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac or vascular surgery	<input type="checkbox"/>	<input type="checkbox"/>
An artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack or other heart problem	<input type="checkbox"/>	<input type="checkbox"/>
A stroke	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you ever Had: GASTROINTESTINAL/URINARY	YES	NO
Persistent diarrhea/odd colored stools	<input type="checkbox"/>	<input type="checkbox"/>
Colitis or ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained vomiting/frequent nausea	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis or other liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice (yellow skin or eyes)	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than twice a night	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease/renal dialysis	<input type="checkbox"/>	<input type="checkbox"/>
A kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>
Any urinary infection	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
Any other sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>

BLOOD /IMMUNE	YES	NO
Bruise easily/bleed excessively	<input type="checkbox"/>	<input type="checkbox"/>
A blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia(cancer of the blood)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes or been frequently thirsty	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid or adrenal gland disease	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or ARC (AIDS Related Complex)	<input type="checkbox"/>	<input type="checkbox"/>
Positive blood test for HIV antibodies	<input type="checkbox"/>	<input type="checkbox"/>
Skin blotches or rash	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic itching	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIES	YES	NO
Have you been allergic or had a reaction to:		
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Dental anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Metals (rings/earrings)	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN ONLY	YES	NO
Do you menstruate regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you flow heavily?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, please give due date	<input type="checkbox"/>	<input type="checkbox"/>
Are you in or have you passed through menopause (change of life)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

Has anyone in your family (grandparent, parent, sibling, child) ever had:	YES	NO	YES	NO
FAMILY HISTORY				
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Mental/emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>

Any genetic diseases/illnesses (please specify)

BEHAVIORAL

YES NO

- Are you available and able to sit for a three-hour dental appointment? YES NO
- Are there some aspects of the appearance of your teeth and jaw that need to be changed? YES NO
- Do you often feel depressed or moody? YES NO
- Do you often feel anxious or nervous? YES NO
- Have you ever had a psychiatric or psychological counseling? YES NO
- Did you ever avoid a dental appointment because you were frightened? YES NO
- Do you ever feel uncomfortable asking questions of doctors? YES NO

List all prescription and non-prescription drugs (including aspirin) taken within the last 6 months:

Name	Dosage	Name	Dosage
1.		3.	
2.		4.	

Please list all hospitalizations and emergency room visits (include dates and reasons):

1.	2.
3.	3.
4.	4.

Have you been dissatisfied with previous dental treatment? _____ YES _____ NO

If yes, please describe: _____

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability.

Patient Signature: _____ Date: _____

(If minor, parent, guardian, or the responsible party)

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer Name: _____

Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services PLEASE READ AND SIGN BELOW

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

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. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Date: _____ Relationship to Patient: _____

PATIENT RELEASE FORM

Viviane Haber DDS

420 W Baseline Rd Ste C Glendora CA 91740

PH# 626 335 1211

1) CHANGES IN TREATMENT PLAN. I understand that as treatment progresses it may be necessary to change or add procedures due to conditions found during the process of treatment that were not readily evident at the exam and diagnosis phase of treatment and of which could require care by a specialist, the cost of which is my responsibility. I give my consent to these changes or additions. I understand that even minor treatment can result in sensitivity and even a routine procedure can necessitate root canal therapy. **Initial** _____

2) MEDICATIONS & ANESTHETICS. I understand that antibiotics, analgesics, anesthetics, medications and other dental supplies/products may be part of treatment and can cause allergic reactions (redness, swelling, pain, itching, vomiting and/or anaphylactic shock) and can change the effectiveness, duration and interact with other medications taken. The injection of anesthetic can cause temporary or indefinite changes in feeling (parasthesia) and motor control. **Initial** _____

3) REMOVAL OF TEETH (EXTRACTION). Alternatives to the removal of teeth have been explained to me as applicable (root canal therapy, crowns, periodontal surgery - etc) and I authorize the removal of Treatment Planned teeth and any others necessary (see paragraph #1). I understand the risks include pain, swelling, discomfort, the spread of infection, dry socket, parasthesia, (a change in feeling in my teeth, lips, tongue and surrounding areas that can be permanent in nature) and/or changes in motor control.

I understand removing teeth does not always remove all of the infection and infection caused changes. These and other complications that may occur during or following treatment may require further treatment by a specialist or even hospitalization, the cost of which is my responsibility. **Initial** _____

4) ROOT CANAL (ENDODONTIC TREATMENT). I understand that a root canal is an attempt to save a tooth and that complications (calcified canals, inaccessible canals, perforation & loss of the canal during treatment, instrument separation in the canal and/or fracture of the tooth crown, body or root) can occur. Other complications can include a reaction to a medication used, pain, swelling, continued infection and sensitivity to pressure even after treatment is completed. These and other complications that may occur during or following treatment may require further treatment (including retreatment, surgery on the root and/or extraction) by a specialist, the cost of which is my responsibility. **Initial** _____

5) FILLINGS. I understand that as treatment progresses, as in any restorative procedure, the cavity (caries) may be greater than expected. **Initial** _____

6) INLAYS, VENEERS, CAPS (CROWNS) AND BRIDGES. I understand that it is not possible to exactly match the color of natural teeth. I realize that the time to request changes (in color, shape, fit and size) is prior to cementation. I realize that permanent crowns are fabricated from materials that can be susceptible to fracture.

I understand that the temporary placed interim to the placement of the permanent is fragile in nature and care must be taken not to break or dislodge it. The temporary is constructed to last only two to three weeks; postponing the placement of the permanent can allow tooth movement, necessitating a remake at an additional charge. **Initial** _____

7) DENTURES-COMPLETE OR PARTIAL. I understand problems in wearing dentures can include looseness, sore spots, decreased ability to speak/eat and breakage. Immediate dentures (dentures placed at the time of the extractions) have more discomfort and require additional adjustments.

I realize that the time to request changes (in color, shape, fit, and size) is at the "teeth in wax" visit. Relines (at an additional fee) will be required as a denture loosens with tissue shrinkage. **Initial** _____

8) GUM (PERIODONTAL) TREATMENT. I understand that I have a serious and progressive disease that can lead to acute infection, pain and tooth loss. Treatment can include cleanings (scaling), deep cleanings (root planing), periodontal surgery (by referral to a specialist) and teeth considered hopeless or teeth that do not respond favorably to treatment will require extraction. I understand that post-therapy my teeth may be sensitive to cold and sweets.

I understand that postponement of care and other factors including the quality of home care can affect my ability to retain my natural dentition. **Initial** _____

9) Implants. I understand that implants have two main parts: an abutment (root form) and a restoration (suprastructure) portion. Poor healing or infection at the surgical site can lead to acute infection, pain and loss of the abutment and/or adjacent teeth. The restorative portion also may come lose or fracture requiring replacing screws or collars, recementation and/or complete loss of the suprastructure. Replacement of the abutment or suprastructure are additional procedures, the cost of which is my responsibility.

I understand that smoking greatly increases the risk of abutment failure.

Initial _____

I understand that dentistry is as much an art as a science and because of this it is impossible to predict the outcome of treatment. I authorize my treating dentist(s) to proceed through the use of medications, materials and therapy as deemed appropriate as treatment progresses.

I have no unanswered questions about treatment benefits/risks, or alternative treatment(s) and their benefits/risks
I have read, understand and agree to the above.

Patient Signature _____ Date: _____ Witness _____
(if minor * parent or guardian) Signature - First MI Last

PERSONAL CONTRACTS

1) MISSED APPOINTMENT CONTRACT. I understand that if I fail to appear on time for my appointment as scheduled without giving the office 48 hour notice: 1) There may be a cancellation fee 2) I will be required to prepay for the next appointment or 3) by my request as an alternative, I will be placed on a will-call list.

Initial _____

2) DENTAL INSURANCE. Dr.Haber promise to make every effort to maximize your insurance reimbursement. The insurance reimbursement will be paid directly to you. We will accept insurance reimbursement, as partial payment only if treatment has been pre-authorized by the insurance company. I understand Dr.Viviane Haber are third parties in the insurance-patient relationship. I also realize that their practice is a fee for service practice and they refuse to compromise service and quality for any reason. By working together as a patient-dentist team, maximum insurance benefits will be achieved without compromising your quality of care.

Initial _____

3) COLLECTIONS. I understand that ultimately I am responsible for all dental care fees. I accept the responsibility for all dental care fees. I accept the responsibility for any reasonable collection and /or legal charges incurred in the recovery of these fees.

Initial _____

4) Patient Acknowledgement of receipt of Dental Materials Fact Sheet: I _____
acknowledge I have received a copy of the Dental Materials Fact Sheet dated October 2001 From Dr.Haber

Patient Signature

Date

Viviane Haber DDS

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

**** You May Refuse to Sign This Acknowledgement ****

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- Other (Please Specify)

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)

Viviane Haber DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED 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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14th 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy 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.

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

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclosure your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us and 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 was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In 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 death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

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

Viviane Haber DDS

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible 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.

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

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

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 using the contact information listed at the end of this Notice. 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 to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page, \$25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative 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. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

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

QUESTIONS AND COMPLAINTS

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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

Contact Officer: Viviane Haber DDS

Telephone: 626-335-1211

Fax: _____

E-mail: vhaberdds@gmail.com

Address: 420 W Baseline Rd Ste C Glendora CA 91740



Cancellation Policy

****IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, OUR OFFICE REQUIRES A 48 HOUR NOTICE. OTHERWISE A CHARGE WILL BE MADE FOR THE TIME RESERVED, IF WE ARE UNABLE TO FILL YOUR APPOINTED TIME.**

THANK YOU FOR YOUR COOPERATION IN HELPING TO KEEP OUR COST DOWN.

Signature

Date



Photography Release

I _____, hereby authorize Dr. Haber to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including but not limited to website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature

Date



Personalized Evaluation

Please answer the following questions that are specifically designed to aid our diagnosis and treatment of your esthetic needs:

- | | | | |
|-----|--|-----|----|
| 1. | Do you dislike the color of your teeth? | Yes | No |
| 2. | Do you have spaces between your teeth? | Yes | No |
| 3. | Do you have chips or uneven edges on your teeth? | Yes | No |
| 4. | Do you have any dark fillings visible? | Yes | No |
| 5. | Are your teeth too short? | Yes | No |
| 6. | Are your teeth too long? | Yes | No |
| 7. | Are your teeth too crowded? | Yes | No |
| 8. | Do your teeth feel “notched” at the gum line | Yes | No |
| 9. | Do your gums show when you are smiling? | Yes | No |
| 10. | Do your gums feel unhealthy? | Yes | No |
| 11. | Do your gums appear irregular in contour? | Yes | No |
| 12. | Have you ever had orthodontic treatment? | Yes | No |
| 13. | Are you satisfied with your facial appearance?
If not, why? _____ | Yes | No |
| 14. | If your smile were improved, would you feel more satisfied? | Yes | No |

In general, how would you improve your smile?

EVALUATOR COMMENTS:

Evaluator's Signature _____