# WELCOME

Date_____

Turley Dental Corporation
14650 Aviation Blvd #175
Manhattan Beach, Ca 90250
(310) 643-0125

## *Confidential Patient Information*

Patient's Name_____ M / F (circle)

Address _____ City_____Zip Code_____How Long_____

Home Phone_____ Birthdate_____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

## *Insurance Information*

Primary Policy Holder's Name _____ and Soc. Sec. #_____

Ins. Company _____Group No._____Union Local No._____

Ins. Co. Address _____Ins. Co. Phone_____

Do you have dual coverage? ☐ No ☐ Yes If yes: E-mail:_____

Secondary Policy Holder's Name_____ and Soc. Sec. #_____

Ins. Company _____Group No._____Union Local No._____

Ins. Co. Address _____Ins. Co. Phone_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____ Update (date & initial)_____

## *Confidential Responsible Party Information*

Name_____ Marital Status_____ M / F (circle)

Residence _____ City_____Zip Code_____How Long_____

Mailing Address _____

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.) _____

Social Security # _____ Birthdate_____Relationship to Patient_____

Employer _____ Occupation_____ No. Years Employed_____

Spouse's Name _____Relationship to Patient_____

Employer _____ Occupation_____ No. Years Employed_____

Social Security # _____ Birthdate_____Work/Cell Phone_____

## *Dental History*

Reason For Orthodontic Examination: _____

Has Patient Had Previous Orthodontic Treatment / Consultation? ☐ Yes ☐ No

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Speech Problems | ☐ Yes | ☐ No | Thumb Sucking | ☐ Yes | ☐ No | Have Tonsils Been Removed | ☐ Yes | ☐ No |
| Lip Biting | ☐ Yes | ☐ No | Finger Biting | ☐ Yes | ☐ No | Food Collection Between Teeth | ☐ Yes | ☐ No |
| Bleeding Gums | ☐ Yes | ☐ No | Grinding Teeth | ☐ Yes | ☐ No | Clicking or Popping of the Jaw | ☐ Yes | ☐ No |
| Periodontal Treatment | ☐ Yes | ☐ No | Mouth Breather | ☐ Yes | ☐ No | Trauma to Teeth or Jaw | ☐ Yes | ☐ No |

## *Medical History*

Physician's Name: _____ Ph. #: _____

Address: _____

If patient is a child:

Has patient reached puberty? ☐ Yes ☐ No Girl - started menstruation? ☐ Yes ☐ No Boy - has voice changed? ☐ Yes ☐ No

Date of last physical exam: _____ Results: _____

Is patient under care of a physician now? Y / N If yes, why _____

Has patient ever been hospitalized? Y / N If yes, why _____

Has patient ever had surgery? Y / N If yes, why _____

HAVE YOU HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO:

| | | | |
|---|---|---|---|
| Y N A.I.D.S./H.I.V. | Y N Cerebral Palsy | Y N Hay Fever | Y N Mental Retardation |
| Y N Anemia | Y N Cleft Lip/Palate | Y N Hearing Problems | Y N Phen Phen |
| Y N Asthma | Y N Convulsion | Y N Heart Problems | Y N Premature Birth |
| Y N Bladder Problems | Y N Developmental Disability | Y N Hepatitis | Y N Rheumatic Fever |
| Y N Blood Transfusion | Y N Diabetes | Y N Jaundice | Y N Sinus Problems |
| Y N Bruise Easily | Y N Epilepsy | Y N Kidney Disease | Y N Thyroid Disease |
| Y N Cancer | Y N Fainting | Y N Liver Disease | Y N Tuberculosis |

Other: _____

Has patient ever had an asthmatic attack? If yes, Mild Moderate Severe And when and how often: _____

Is patient receiving any medication? Y / N If yes, list names and purpose: _____

_____

ARE YOU ALLERGIC TO, OR EVER HAD AN ADVERSE REACTION TO THE FOLLOWING? IF YES, PLEASE CIRCLE:

Aspirin Barbiturates Sedatives Metal Local Anesthetics Amoxicillin Sleeping Pills Sulfa Drugs Latex None Known Any others _____

***I understand that the information that I have given is correct, that it will be held in confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.***

***Signature*** _____ ***Date*** _____

# RISK ASSESSMENT

Child's Name _____ Date _____

Child's Age _____

Birth Date _____ Child's next dental care visit: _____

**ABC's of Infant Oral Health**

| | Yes | No |
|---|---|---|
| **HEALTH HISTORY** | | |
| Did birthmother have any problems during pregnancy? | ☐ | ☐ |
| Was child premature? | ☐ | ☐ |
| Was child's birth weight low? | ☐ | ☐ |
| Were there any complications at birth? | ☐ | ☐ |
| Has your infant been ill? | ☐ | ☐ |
| Is your child on any medications? | ☐ | ☐ |
| **DIET AND NUTRITION** | | |
| Is/ was your child breastfed? | ☐ | ☐ |
| Does your child sleep with a bottle? | ☐ | ☐ |
| Does your child drink from a cup? | ☐ | ☐ |
| Is your child on a special diet? | ☐ | ☐ |
| **FLUORIDE ADEQUACY** | | |
| Do you know the fluoride level of your water? | ☐ | ☐ |
| Do you have well water? | ☐ | ☐ |
| If yes, has the water been tested? | ☐ | ☐ |
| Do you use bottled water? | ☐ | ☐ |
| Do you use a water conditioner or filtration system? | ☐ | ☐ |
| If yes, please list_____ | | |
| Do you use a fluoridated toothpaste for your child? | ☐ | ☐ |
| **ORAL HABITS** | | |
| Does your child use a pacifier? | ☐ | ☐ |
| Does your child suck a thumb or fingers? | ☐ | ☐ |
| Does your child grind teeth day or night? | ☐ | ☐ |
| **INJURY PREVENTION** | | |
| Is your child walking? | ☐ | ☐ |
| Is your home childproofed? | ☐ | ☐ |
| Do you use a car seat for your child? | ☐ | ☐ |
| Has your child had an oral/facial injury? | ☐ | ☐ |
| **ORAL DEVELOPMENT** | | |
| Does your child have any teeth? | ☐ | ☐ |
| Child's age (in months) when first tooth erupted?_____ | ☐ | ☐ |
| Has your child experienced teething problems? | ☐ | ☐ |
| Have you noticed any oral problems in your child? | ☐ | ☐ |
| **ORAL HYGIENE** | | |
| Do you clean your child's teeth / gums? | ☐ | ☐ |
| Do you use a toothbrush to clean your child's teeth? | ☐ | ☐ |
| Do you use toothpaste to clean your child's teeth? | ☐ | ☐ |

## KEEPING BABY TEETH HEALTHY

Proper use of the bottle is the first step in preventing dental problems.

- Bottles are used to feed babies who are not yet able to drink from a cup.
- Feed only formula, breast milk or water from a bottle.
- Offer the bottle only at feeding times. Do not let baby carry a bottle around at other times. A bottle is not a toy or pacifier.
- Sleeping times are not feeding times. Do not put baby to bed with a bottle.

## THE BEDTIME BOTTLE

**The baby who goes to bed with a bottle can get painful tooth decay. This is called "nursing bottle mouth."**

The sugar in formula, milk, juice and sweetened drinks can decay the teeth if it stays in baby's mouth during sleep.

Offer a blanket, stuffed animal or favorite toy instead of a bottle at sleeptime.

## IT'S TIME FOR A CUP

**When your baby is able to sit well, begin offering water from a small cup.**

Be patient . . . it will take your baby time to learn to drink from a cup.

As baby gets used to drinking from a cup, offer formula, breast milk or juice in a cup.

Take bottles away gradually. Most babies will not want to give up the bottle all at once.

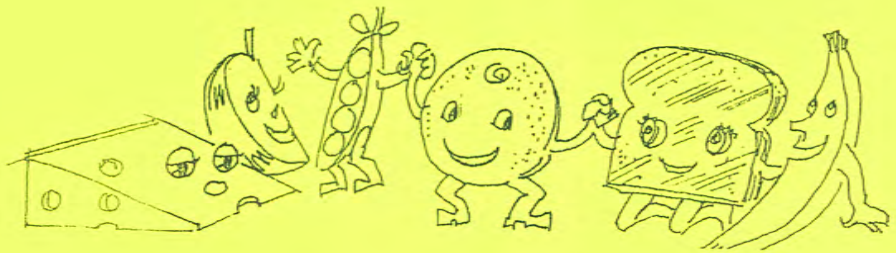
Babies should be drinking from a cup by their first birthday.

By eighteen months of age, the bottle should no longer be used.

## GOOD NUTRITION FOR HEALTHY TEETH

**Nutritious foods and beverages are needed for healthy teeth and gums.**

- Encourage good eating habits. Choose a variety of foods from each of the food groups. Set regular meal and snack times.
- When your child is thirsty, offer water. Avoid sweet drinks such as soda pop, Hi-C®, Kool-aid®, Tang® and fruit punch.
- Help your child control a "sweet tooth." Avoid candy, cookies, cake, pastries, Jello®, doughnuts, granola bars and baby desserts.




Turley Dental Corp.
**Dr. Patricia N. Turley**
Practice Limited to
Pediatric Dentistry

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(Between Rosecrans and Marine)

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# Dr. Patricia Turley
## Pediatric Dentistry
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(310) 643-0125


## FINANCIAL POLICY

All payments are due at the time services are rendered. For your convenience we accept Visa, MasterCard, American Express and personal checks.
A $50.00 fee will be automatically charged for retuned checks. For extensive dental treatment we do offer financing through Care Credit. For your service, this is a flexible plan option. All invoices more than 60 days overdue will incur a finance charge of 1.5% monthly, 18% APR.

## INSURANCE

We submit insurance claims as a courtesy to our patients. Please provide our office with the most accurate information. If a claim is denied due to incorrect information provided by you, we will provide you with the statement so that you can send it to you insurance company. By law, an insurance carrier has 30 days to respond to and/or pay the claim. If your insurance does not pay within 30 days, the balance will be your responsibility.

## MISSED APPOINTMENTS

Our office reserves the time slots specifically for your child. Please provide us with 48 hours of notice if you need to cancel or change your appointment. If your cancellation is less than 48 hours we will be unable to give the space to another child. For missed appointments or cancellations less than 48 hours, the accounting office will charge a $50.00 fee which is subject to collection. We respect everyone's time.

_____

Parent Signature

_____

Date

# 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

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

# NOTICE OF PRIVACY PRACTICES

## THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU 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

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

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

### USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

**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 an authorization, you may revoke it in writing at any6 time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you five us a written authorization, we cannot use or disclose you health information for any reason except those described in this 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 you 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 you 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.

**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, counterintellingence, and other national security activities. We may disclose to correctional institutional or law enforcement official having lawful 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 $0.25 for each page, $15.00 per hour of 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 oncein 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 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## QUESTIONS AND COMPLAINTS\

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

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

Dr. Patricia N. Turley
Practice Limited to Pediatric Dentistry
11980 San Vicente Blvd. #802 Los Angeles, Ca. 90049
Phone: (310) 820-3221 Fax: (310) 820-2296

**Patient Acknowledgement of**
**Receipt of Dental Materials Fact Sheet**

I acknowledge I have received from the office of Patricia N. Turley, D.D.S., a copy of Dental Materials Fact Sheet.

_____

*Printed Name of Patient/Guardian*

_____

*Patient/Guardian Signature* *Date*

The following document is the Dental Board of California's Dental Material Fact Sheet. **The Dental Board of California Dental Materials Fact Sheet** was adopted by the Board on October 17, 2001. As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize the information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and the dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental material science. The most frequently used materials in restorative dentistry are amalgam, composite resin, glass-ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials". A "Glossary of Terms" is also attached to assist the reader in understanding the terms used. The statements made are supported by relevant, credible dental research published mainly between the years of 1993-2001. In some cases, where contemporary is sparese, we have indicated our best perceptions based upon the information that predates 1993. The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material freom which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with the dental hygiene and the home care, their diet and chewing habits.

# Comparisons of InDirect Restorative Dental Materials

| TYPES OF INDIRECT RESTORATIVE DENTAL MATERIALS | | | | |
|---|---|---|---|---|
| COMPARATIVE FACTORS | PORCELAIN (CERAMIC) | PORCELAIN (FUSED-TO-METAL) | GOLD ALLOYS (NOBLE) | NICKEL OR COBALT-CHROME (BASE-METAL) ALLOYS |
| General Description | Glass-like material formed into fillings and crowns using models of the prepared teeth. | Glass-like material that is "enameled" onto metal shells. Used for crowns and fixed-bridges. | Mixtures of gold, copper and other metals used mainly for crowns and fixed bridges. | Mixtures of nickel, chromium. |
| Principle Uses | Inlays, veneers, crowns and fixed-bridges. | Crowns and fixed-bridges. | Cast crowns and fixed bridges; some partial denture frameworks. | Crowns and fixed bridges; most partial denture frameworks. |
| Resistance to Further Decay | Good, if the restoration fits well. | Good, if the restoration fits well. | Good if the restoration fits well. | Good if the restoration fits well. |
| Estimated Durability (permanent teeth) | Moderate; Brittle material that may fracture under high biting forces. Not recommended for posterior (molar) teeth. | Very good. Less susceptible to fracture due to the metal substructure. | Excellent. Does not fracture under stress; does not corrode in the mouth. | Excellent. Does not fracture under stress; does not corrode in the mouth. |
| Relative Amount of Tooth Preserved | Good - Moderate. Little removal of natural tooth is necessary for veneers; more for crowns since strength is related to its bulk. | Moderate-High. More tooth must be removed to permit the metal to accompany the porcelain. | Good. A strong material that requires removal of a thin outside layer of the tooth. | Good. A strong material that requires removal of a thin outside layer of the tooth. |
| Resistance to Surface Wear | Resistant to surface wear; but abrasive to opposing teeth. | Resistant to surface wear; permits either metal or porcelain on the biting surface of crowns and bridges. | Similar hardness to natural enamel; does not abrade opposing teeth. | Harder than natural enamel but minimally abrasive to opposing natural teeth. does not fracture in bulk. |
| Resistance to Fracture | Poor resistance to fracture. | Porcelain may fracture. | Does not fracture in bulk. | Does not fracture in bulk. |
| Resistance to Leakage | Very good. Can be fabricated for very accurate fit of the margins of the crowns. | Good – Very good depending upon design of the margins of the crowns. | Very good – Excellent. Can be formed with great precision and can be tightly adapted to the tooth. | Good-Very good – Stiffer than gold; less adaptable, but can be formed with great precision. |
| Resistance to Occlusal Stress | Moderate; brittle material susceptible to fracture under biting forces. | Very good. Metal substructure gives high resistance to fracture. | Excellent | Excellent |
| Toxicity | Excellent. No known adverse effects. | Very Good to Excellent. Occasional/rare allergy to metal alloys used. | Excellent; Rare allergy to some alloys. | Good; Nickel allergies are common among women, although rarely manifested in dental restorations. |
| Allergic or Adverse Reactions | None | Rare. Occasional allergy to metal substructures. | Rare; occasional allergic reactions seen in susceptible individuals . | Occasional; infrequent reactions to nickel. |
| Susceptibility to Post-Operative Sensitivity | Not material dependent; does not conduct heat and cold well. | Not material dependent; dies not conduct heat and cold well. | Conducts heat and cold; may irritate sensitive teeth. | Conducts heat and cold; may irritate sensitive teeth. |
| Esthetics (Appearance) | Excellent | Good to Excellent | Poor – yellow metal | Poor – dark silver metal |
| Frequency of Repair or Replacement | Varies; depends upon biting forces; fractures of molar teeth are more likely than anterior teeth; porcelain fracture may often be repaired with composite resin. | Infrequent; porcelain fracture can often be repaired with composite resin. | Infrequent; replacement is usually due to recurrent decay around margins | Infrequent; replacement is usually due to recurrent decay around margins. |
| Relative Costs to Patient | High; requires at least two office visits and laboratory services. | High; requires at least two office visits and laboratory services. | High; requires at least two office visits and laboratory services. | High; requires at least two office visits and laboratory services. |
| Number of Visits Required | Two – minimum; matching esthetics of teeth may require more visits. | Two - minimum; matching esthetics of teeth may require more visits. | Two - minimum | Two - minimum |