Herman Ostrow School of Dentistry of USC

Faculty Practice

The faculty, students and staff at the Herman Ostrow School of Dentistry of USC Faculty Practice are committed to ensuring that you receive the highest quality of care and service.

We have developed a Patient's Bill of Rights and Responsibilities (see the following pages) that reflects our standards for delivery of patient care. While we strive to provide you the highest standards of care, it is possible that you may feel that we have not achieved our goals. If you are dissatisfied with the care you are receiving, we hope that you will bring your concerns to our attention. We are also anxious to hear about positive experiences you have had and any individuals who were particularly competent, helpful, and courteous or who otherwise made your experience in our dental clinic a good one. We welcome any comments or suggestions you may have that will help us to serve you better.

Patient comment forms are available in all clinic offices for your use. Completed forms may be returned to any office or you can mail your comments to the Herman Ostrow School of Dentistry of USC Office of Quality Assurance, 925 West 34th Street, University Park MC 0641, Los Angeles, California 90089-0641.

We are pleased that you have selected the Faculty Practice of the Herman Ostrow School of Dentistry of USC to be your dental care provider and look forward to serving your needs.

Douglas Solow, DDS, MBA
Associate Dean for Clinical Affairs

Nondiscrimination in Services Policy

Admissions, the provision of services, and referrals of patients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or sex.

Services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations.

Any patient, parent and/or their guardian who believes they have been discriminated against may file a complaint of discrimination with:

USC's Office of Equity and Diversity
Phone Number: (213) 740-5086

FP 05222014
Welcome to the Herman Ostrow School of Dentistry of USC Faculty Practice. It is our goal to provide each patient with the best possible care throughout the course of his or her treatment. Please carefully review our office policies and feel free to discuss them with our staff.

1. Keep in mind that you are ultimately responsible for any and all charges for treatment rendered, regardless of insurance coverage. We will gladly process your insurance claims (Delta Dental PPO only), and any portion of your treatment not covered by insurance is payable at your appointment. Please be sure that you understand your treatment costs. If you have a question regarding the cost of a procedure, please ask our staff.

2. Patients covered under the USC Delta Dental PPO Plan ("Delta Dental"):  
   a. Verify your eligibility with the Delta Dental Plan. Any questions about your eligibility should be directed to the USC Benefits Department.
   b. USC Delta Dental PPO covers 100% of allowable charges up to a $1,500.00 maximum per calendar year. Remember that Delta Dental has exclusions in coverage; please review the Evidence of Coverage booklet, which can be obtained from the USC Benefits Department. You are responsible for charges that are not covered by Delta Dental.
   c. Delta Dental covers two (2) hygiene appointments (cleanings) per year. These are not free; their costs are deducted from the annual maximum. If your recommended treatment is more than two (2) cleanings per year, then you will be responsible for the costs of the additional cleaning(s).
   d. All charges that surpass the $1,500.00 annual maximum are the responsibility of the patient. Please keep a record of your treatment and costs. This information can be obtained from our staff.

3. Patients covered by another insurance other than the USC Delta Dental plan:  
   a. Supply our office with full insurance information on all dental plans.
   b. Please be aware that you may have co-payments for office visits, depending on the insurance coverage.

4. Please arrange for childcare; our staff cannot monitor children during your treatment.

5. A parent must accompany all patients who are under 18 years of age. Due to legal and safety issues, the parent must remain in our office for the duration of the appointment.

6. The patient is responsible for making and keeping appointments. If you need to cancel, please inform our office at least 24 business hours prior to your scheduled visit. You may leave a message on our answering service if you are unable to reach our staff (please also see number eight (8) below).
7. In fairness to other patients, we reserve the sole right to reschedule your appointment if you are more than 15 minutes late, depending on the circumstances.

8. Failure to inform our office of a cancellation at least 24 business hours prior to an appointment, or arriving late for an appointment that results in your being rescheduled, is considered a "missed appointment", which may result in a $50.00 fee. This fee must be paid by you before scheduling another appointment. Insurance companies do not cover missed appointment fees. The Faculty Practice attempts to make courtesy confirmation calls; however, the lack of receipt of a call does not change this policy.

_________________________   _________________________
Patient/Parent/Guardian Signature   Date

_________________________
Print Name

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Patient Initials_________
INSURANCE ACCEPTANCE POLICIES

The Herman Ostrow School of Dentistry of USC Faculty Practice is a contracted provider for Delta Dental* Insurance Company and the USC Network Medical Plan ONLY. We will bill these insurance companies for treatment rendered. However, the patient is ULTIMATELY responsible for all fees and costs associated with their treatment.

IF INSURANCE PAYMENT IS DENIED OR PAYMENT HAS NOT BEEN RECEIVED WITHIN 90 DAYS FROM THE FACULTY PRACTICE’S CLAIM SUBMISSION TO THE INSURANCE COMPANY, THE PATIENT WILL BE BILLED FOR THE BALANCE DUE.

The Faculty Practice does NOT bill or submit insurance claims or any other claims for other insurance carriers and/or payers. Payment is expected when services are rendered. The Faculty Practice will be happy to provide the patient with an itemized statement that can be submitted to the patient’s insurance carrier by the patient.

*The Faculty Practice is a contracted Premier Provider for those on the USC Delta Dental PPO plan; for all others, the Faculty Practice is a contracted Delta Dental PPO provider, except for Prosthodontic (general/restorative dentistry) services, for which the Faculty Practice is an out-of-network provider. As an out-of-network provider, the patient cost for these services will be higher. It is the patient’s responsibility to check eligibility for coverage and associated costs. The Faculty Practice does not accept Delta Dental DMO or any other PPO/DMO insurance.

________________________
Print Name

________________________
Signature

________________________
Date

FP 05222014
Patient Bill of Rights and Responsibilities

The Herman Ostrow School of Dentistry of USC and its Affiliated Practices strives to provide a high quality of care and service to our patients. As a valued patient you have the following rights and responsibilities:

- **You have a right** to an appointment with your healthcare provider in a timely manner.

- **You have a right** to considerate, respectful, and confidential treatment.

- **You have a right** to have complete and current information about your condition.

- **You have a right** to know in advance the type and expected cost of treatment.

- **You have a right** to expect healthcare providers to use appropriate infection and sterilization controls.

- **You have a right** to an explanation of the prescribed treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of these treatments, and be told, in language you can understand, the advantages and disadvantages of each.

- **You have a right** to ask your healthcare provider to explain all the treatment options regardless of your insurance benefit coverage or cost.

- **You have a responsibility** to keep your appointment, or reschedule in a timely manner.

- **You have a responsibility** to be considerate and respectful to others like your healthcare members and other patients.

- **You have a responsibility** to provide complete and current information about your condition.

- **You have a responsibility** to participate in your care and keep current on your cost of treatment and insurance coverage, if any.

- **You have a responsibility** to dress and present yourself appropriately.

- **You have a responsibility**, as well as you are able, to participate in prescribed treatment, carefully weigh the consequences of accepting or refusing treatment, and appropriately discuss changes that might occur during your course of care.

- **You have a responsibility** to make reasonable decisions within yours and the school’s limitations.
UNIVERSITY OF SOUTHERN CALIFORNIA
NOTICE OF PRIVACY PRACTICES

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

What is this Notice and Why Is It Important?
By law, the University of Southern California (USC)\(^1\) must protect the privacy of your identifiable medical and other health information ("health information").

USC also is required by law to give you this notice to tell you how we may use and give out ("disclose") your health information. USC must follow the terms of this notice when using or disclosing your health information.

This notice is effective as of July 1, 2013.

How USC May Use Your Health Information
As a general rule, you must give written permission before USC can use or release your health information. There are certain situations where USC is not required to obtain your permission. This section explains those situations where USC may use or disclose your health information without your permission.

Except with respect to Highly Confidential Information (described below), USC is permitted to use your health information for the following purposes:

- **Treatment:** We use and disclose your health information to provide you with medical treatment or services. This includes uses and disclosures to:
  - treat your illness or injury, including disclosures to other doctors, practitioners, nurses, technicians or medical personnel involved in your treatment, or
  - contact you to provide appointment reminders, or
  - give you information about treatment options or other health related benefits and services that may interest you.

- **Payment:** We may use and disclose your health information to obtain payment for health care services that we or others provide to you. This includes uses and disclosures to:
  - submit health information and receive payment from your health insurer, HMO, or other company that pays the cost of some or all of your health care (payor), or
  - verify that your payor will pay for your health care.

However, we will comply with your request not to disclose health information to your health plan if the information relates solely to a healthcare item or service for which we have been paid out of pocket in full.

- **Health Care Operations:** We may use and disclose your health information for our health care operations, such as internal administration and planning that improve the quality and cost effectiveness of the care we provide you. This also include uses and disclosures to:

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\(^1\) USC includes USC Norris Cancer Hospital, Keck Hospital of USC, USC's employed physicians, nurses and other clinical personnel, those units of USC that provide clinical services within the School of Pharmacy, the Herman Ostrow School of Dentistry, Physical and Occupational Therapy as well as the Keck Doctors of USC, those units that support clinical and clinical research functions, including the Offices of the General Counsel, Audit and Compliance, and Verdugo Hills Hospital, nurses, other clinical personnel, Verdugo Radiology Medical Group, Verdugo Hills Anesthesia, and Chandnish K. Ahlawat, M.D., Inc.
- evaluate the quality and competence of our health care providers, nurses and other health care workers,
- to other health care providers to help them conduct their own quality reviews, compliance activities or other health care operations,
- train students, residents and fellows, or
- identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

We may also disclose your health information to third parties to assist us in these activities (but only if they agree in writing to maintain the confidentiality of your health information).

In addition, USC may use and disclose your health information under the following circumstances:

- **Directory:** USC may include your name, location in its hospitals, general health condition and religious affiliation in a patient directory without obtaining your authorization unless you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy; provided, however, that your religious affiliation will only be disclosed to members of the clergy.

- **Relatives, Caregivers and Personal Representatives:** Under appropriate circumstances, including emergencies, we may disclose your health information to family members, caregivers or personal representatives who are with you or appear on your behalf (for example, to pick up a prescription). We may also need to notify such persons of your location in our facility and general condition. If you object to such disclosures, please notify your USC health care provider. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, we would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care.

- **Public Health Activities:** We may disclose your health information for the following public health activities:
  - To report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
  - To report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports;
  - To report information to the U.S. Food and Drug Administration (FDA) about products and services under its jurisdiction;
  - To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease; or
  - To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

- **Victims of Abuse, Neglect or Domestic Violence:** If we reasonably believe that you are a victim of abuse, neglect or domestic violence, we may disclose your health information as required by law to a social services or other governmental agency authorized by law to receive such reports.

- **Health Oversight Activities:** We may disclose your health information to a health oversight agency that is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.
• **Specialized Government Functions:** We may use and disclose your health information to units of the government with special functions, such as the U.S. military, under certain circumstances required by law.

• **Law Enforcement Officials, Judicial and Administrative Proceedings:** We may disclose health information to police or other law enforcement officials. We also may disclose health information in judicial or administrative proceedings, such as in response to a subpoena.

• **Coroners or Medical Examiners:** We may disclose health information to a coroner or a medical examiner as required by law.

• **Organ and Tissue Donation:** We may disclose health information to organizations that assist with organ, eye or tissue donation, banking or transplant.

• **Health or Safety:** We may disclose health information to prevent a serious threat to your health and safety or the health and safety of the public or another person.

• **Research:** We may disclose health information without your authorization for certain research purposes. For example, we may disclose your information to researchers preparing a research protocol or if our Institutional Review Board committee (which is charged with ensuring the protection of human subjects in research) determines that an authorization is not necessary if certain criteria are met. We also may provide health information about you (not including your name, address, or other direct identifiers) for research, public health or health care operations, but only if the recipient of such information signs an agreement to protect the information and not use it to identify you.

• **Development Activities:** We may contact you to request a contribution to support important USC activities. In connection with any fundraising, we may disclose to our fundraising staff only demographic information about you (for example, your name, address and phone number), dates on which we provided health care to you, information about the department of service or treating physician, outcome information or health insurance status without your written permission. We also may share such information about you with closely related foundations that assist us in our development activities. We will provide you an opportunity to opt-out of receiving fundraising communications. We will not disclose your diagnosis or treatment, however, unless we have your written authorization to do so.

• **Marketing Activities:** We may conduct the following activities without obtaining your authorization:
  - Provide you with marketing materials in a face-to-face encounter;
  - Give you a promotional gift of nominal value;
  - Provide refill reminders or otherwise communicate about a drug or biologic that is currently prescribed to you, so long as any payments we receive for making the communication are reasonably related to our costs;
  - Tell you about USC’s own health care products and services.

We may accept payments from other organizations or individuals in exchange for telling you about their health care products or services. In those cases, we will ask for your authorization, except as described above or unless the communications are permitted by law without your permission. We will ask your permission to use your health information for any other marketing activities. Also, from time to time, USC receives letters from patients, their family members and friends describing the experience and care they received at USC. Where possible, we share these letters with our USC
employees and patients. Prior to sharing your letter, we will remove your name and other identifying information from the letter to protect your privacy.

- **Workers’ Compensation:** We may disclose health information as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs or as required under laws relating to workplace injury and illness.

- **As Required by Law:** We may disclose health information when required to do so by any other law not already referred to in the preceding categories.

**Your Written Authorization**

FOR ANY PURPOSE OTHER THAN THE ONES DESCRIBED ABOVE WE MAY ONLY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN YOU GIVE US YOUR WRITTEN AUTHORIZATION.

**Highly Confidential Information**

Federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including your health information that is maintained in psychotherapy notes or is about: (1) mental health and developmental disabilities services; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic or elder abuse; or (8) sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

**Sale of Health Information**

We will not make any disclosure that is considered a sale of your protected health information without your written authorization unless the disclosure is for a purpose permitted by law.

**Your Rights Regarding Your Health Information**

**Right to Request Access to Your Health Information:** You have the right to inspect and maintain a copy of the patient records we maintain to make decisions about your treatment and care, including billing records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you would like access to your records, please ask your healthcare provider for the appropriate form to complete. If you request copies, we will charge you a reasonable fee for copies. We also will charge you for our postage costs, if you request that we mail the copies to you. If you are a parent or legal guardian of a minor, certain portions of the minor’s medical record may not be accessible to you under California law.

**Right to Request Amendments to Your Health Information:** You have the right to request that we amend your health information maintained in your medical record file or billing records. If you wish to amend your records, please obtain an amendment request form from your healthcare provider. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is already accurate and complete or other special circumstances apply.

**Right to Revoke Your Authorization:** You may revoke (take back) any written authorization obtained by us for use and disclosure of your protected health information, except to the extent that we have taken action in reliance upon it. Your revocation must be in writing and sent to the USC Office of Compliance or to whomever is indicated on your authorization.
Right to An Accounting of Disclosures of Your Health Information: Upon written request, you may obtain an accounting of certain disclosures of health information made by us. The period of your request cannot exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you a reasonable fee.

Right to Request how Information is Provided to You: You may request, and we will try to accommodate, any reasonable written request for you to receive health information by alternative means of communication or at a different address or location.

Right to Request Restrictions on the use of your Health Information: You may request that we restrict the use or disclosure of your protected health information. All requests for such restrictions must be made in writing. While we will consider a request for additional restrictions carefully, we are not required to agree to a requested restriction, except for requests to restrict disclosure of information to a health plan in cases where you have paid for the service out of pocket and in full.

Right to be Notified of Breach: You have the right to be notified by us if we discover a breach of your unsecured protected health information.

Right to a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such information electronically.

Right to Change Terms of this Notice
We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all health information that we hold, including any information created or received prior to issuing the new notice. If we change this notice, we will post the revised notice in our practice areas and on our website at www.usc.edu/compliance. You may also obtain any revised notice by contacting the USC Office of Compliance.

Further Information; Complaints
If you would like additional information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to health information, you may contact our USC Office of Compliance. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the USC Office of Compliance will provide you with the current address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

USC Office of Compliance
You may contact the USC Office of Compliance at: 3500 Figueroa, #105, Los Angeles, CA 90089-8007. (213) 740-8258 or compliant@usc.edu.
UNIVERSITY OF SOUTHERN CALIFORNIA
NOTICE OF PRIVACY PRACTICES

Please sign and date below to indicate that you have received a copy of this notice. Your signature simply acknowledges that you received a copy of this notice.

________________________________________
Print Name (Last, First, Middle Initial)

________________________________________
Signature

________________________________________
Date
Dental Materials – Advantages & Disadvantages

PORCELAIN FUSED TO METAL
This type of porcelain is a glass-like material that is “enameled” on top of metal shells. It is tooth-colored and is used for crowns and fixed bridges

Advantages
- Good resistance to further decay if the restoration fits well
- Very durable, due to metal substructure
- The material does not cause tooth sensitivity
- Resists leakage because it can be shaped for a very accurate fit

Disadvantages
- 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 and fixed bridges and some partial denture frameworks

Advantages
- 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

Disadvantages
- 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
Dental Materials Fact Sheet

What About the Safety of Filling Materials?

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 law* to make this dental materials fact sheet available to every licensed dentist in the state of California. Your 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 parent/guardian, you are strongly encouraged to discuss with your dentist the facts presented concerning the filling materials being considered for your particular treatment.

* Business and Professions Code 1648.10-1648.20

Allergic Reactions to Dental Materials

Components in dental fillings may have side effects or 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.

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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**
- 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
- 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

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NICKEL OR COBALT-CHROME ALLOYS

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

**Advantages**
- 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

**Disadvantages**
- Is not tooth colored; alloy is a dark silver metal 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
- Slightly higher wear to opposing teeth
Dental Materials – Advantages & Disadvantages

GLASS Ionomer Cement
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
- Reasonably good esthetics
- May provide some help against decay because it releases fluoride
- Minimal amount of tooth needs to be removed and it bonds well to both the enamel and the dentin beneath the enamel
- Material has low incidence of producing tooth sensitivity
- Usually completed in one dental visit

Disadvantages
- Cost is very 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 the accumulation of plaque and chance of periodontal disease
- Does not wear well; tends to crack over time and can be dislodged

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 fillings, cementing metal and porcelain metal crowns and liners.

Advantages
- Very good esthetics
- May provide some help against decay because it releases fluoride
- Minimal amount of tooth needs to be removed and it bonds well to both the 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

Disadvantages
- Cost is very similar to composite resin (which costs more than amalgam)
- Limited use because it is not recommended to restore the biting surfaces of adults
- Wears faster than composite and amalgam

Toxicity of Dental Materials

Dental Amalgam
Mercury in its 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 (43-54%) 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 from dental amalgams in their mouths. The FDA places no restrictions 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

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

Advantages
- Durable; long lasting
- Wears well; holds up well to the forces of biting
- Relatively inexpensive
- Generally completed in one 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

Disadvantages
- Refer to "What About the Safety of Filling Materials"
- Gray colored, not tooth colored
- May darken as it corrodes; may stain teeth over time
- Requires 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 a temporary sensitivity to hot and cold.
- Contact with other metals may cause occasional, minute electrical flow

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

COMPOSITE RESIN FILLINGS
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
- 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 holds 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

Disadvantages
- Refer to "What About the Safety of Filling Materials"
- 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

The Facts About Fillings
I acknowledge that I have received from the Herman Ostrow School of Dentistry of USC Faculty Practice a copy of the Dental Materials Fact Sheet dated October 2004.

Print Patient Name (Last, First, Middle Initial)

______________________________________________

X

Signature

Date
# Application for Treatment

## Patient Information

(To be completed by the patient – Please PRINT in ink)

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<th>Field</th>
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<tr>
<td>Home Address</td>
<td>___________________________</td>
</tr>
<tr>
<td>City</td>
<td>___________________________</td>
</tr>
<tr>
<td>State</td>
<td>___________________________</td>
</tr>
<tr>
<td>Zip Code</td>
<td>___________________________</td>
</tr>
<tr>
<td>Home Phone</td>
<td>( ) ________________________</td>
</tr>
<tr>
<td>Work Phone</td>
<td>( ) ________________________</td>
</tr>
<tr>
<td>Cell Phone</td>
<td>( ) ________________________</td>
</tr>
<tr>
<td>Email address</td>
<td>___________________________</td>
</tr>
<tr>
<td>Driver’s License</td>
<td>___________________________</td>
</tr>
<tr>
<td>California ID</td>
<td>___________________________</td>
</tr>
<tr>
<td>Passport</td>
<td>___________________________</td>
</tr>
<tr>
<td>Employer</td>
<td>___________________________</td>
</tr>
<tr>
<td>Sex</td>
<td>☐ Male ☐ Female ☐ Other</td>
</tr>
<tr>
<td>Birth date</td>
<td>___________________________</td>
</tr>
<tr>
<td>Primary Language(s) Spoken</td>
<td>___________________________</td>
</tr>
<tr>
<td>Are you associated with USC?</td>
<td>☐ Yes ☐ No If so, how?</td>
</tr>
</tbody>
</table>

Emergency Contact: ___________________________ Relationship: ___________________________

Emergency Contact Phone: ( ) ___________________________

Major dental problem/reason for coming to USC School of Dentistry: ___________________________

## Insurance/Financial Information

(To be completed by the patient – Please PRINT in ink)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previously a patient here?</td>
<td>☐ Yes ☐ No Year</td>
</tr>
<tr>
<td>Insurance Carrier Name</td>
<td>___________________________</td>
</tr>
<tr>
<td>Insurer</td>
<td>___________________________</td>
</tr>
<tr>
<td>Subscriber</td>
<td>___________________________</td>
</tr>
<tr>
<td>Subs. Birthdate</td>
<td>___________________________</td>
</tr>
<tr>
<td>Relationship</td>
<td>___________________________</td>
</tr>
<tr>
<td>Plan #</td>
<td>___________________________</td>
</tr>
<tr>
<td>Person Responsible for Payment</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

Please be aware that your dental insurance may not pay for the total amount of your treatment and you may be responsible for any co-pays or amount that your insurance company does not cover. Your completion of this form is your agreement to this responsibility.

Revised FP 05222014
The Herman Ostrow School of Dentistry
Patient Understanding and Informed Consent

General Information: The Ostrow School of Dentistry will be referred to as the “School” in this document. The Faculty Practice is the School’s faculty practice. Patients will receive dental care here by faculty dentists and staff hygienists of The School. The School reserves the right to deny acceptance of patients into our dental treatment programs.

Emergency Care:

If an emergency or postoperative complication arises after hours or on a weekend or holiday, please call 213 740-2012 and a doctor on call will be contacted to assist you.

Consent to Dental Procedures: Before you receive treatment, you are encouraged to ask your faculty dentists and staff hygienists of The School about the procedures he/she recommends for you. Ask any questions you might have before you decide to give your consent for treatment. All dental procedures may involve risks or unsuccessful results and complications, and no guarantees are made regarding any result or cure. You, as our patient, have the right to be informed of any such risks and potential consequences of not performing treatment, the nature of the procedure, expected benefits, and availability of alternative methods of treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance. The School also reserves the right not to perform specific treatment requested by a patient.

Health: If you have any changes in your health status or changes in your medicines, you will inform your dental provider. If you are taking a type of drug called bisphosphonate (i.e. Fosamax®, Actonel®, Boniva®, Skelax®, Didronel®, Aredia®, Zometa® and Bonefos®), you may be at risk of developing osteonecrosis (bone death) of the jaw and certain dental treatment may increase that risk.

X-rays: Dental x-rays will be taken as necessary and appropriate for examinations, diagnoses, consultations, and treatments.

Photographs: Patient photographs may be taken to document a clinical condition, to record examination findings, and/or for teaching purposes.

Patient’s Financial Responsibility: Patients who receive treatment at the Practice will be charged for treatment based on the Practice’s current fee schedule. A fee estimate will be provided before beginning treatment. Payment for services is due when treatment is rendered. As a courtesy, the Practice will bill Delta Dental for Delta Dental patients covered by USC’s Delta Dental plan. Any co-pays, co-insurance, or over the benefits limit fees due are the responsibility of the patient or guarantor at the time service is rendered. Patients must also provide personal identification that may include their social security numbers to process dental insurance claims and/or to request patient record information.

Keeping Your Appointments: You are required to be on time for your appointments. If you find that you are unable to keep an appointment, you agree to notify the Practice at least 24 business hours in advance. Appointments cancelled without at least 24 business hours’ notice may result in a “Missed Appointment” fee.

Discontinuance of Treatment: The Faculty Practice reserves the right to discontinue your dental treatment. Should your treatment be stopped, any remaining credit balance for services not yet provided will be refunded to you.

Grievances: Please discuss any grievances with the Faculty Practice’s Office Manager or Senior Clinical Administrator. Both may be reached by calling 213-740-2012 or via email at dentists@usc.edu. If you have

concerns that your doctor or practice management cannot resolve, please contact our Patient Advocate at the Ostrow School of Dentistry of USC, Office of Clinical Affairs at telephone number 213-740-1774 or via email: patientfeedback@usc.edu.

Security: You understand that for security purposes cameras are present throughout the School.

Release: You hereby agree to release, hold harmless and waive all claims, losses, or damages resulting or relating to the treatment rendered hereunder by the student doctor, resident, student dental hygienist, faculty or School.

Release: You hereby agree to release, hold harmless and waive all claims, losses, or damages resulting or relating to the treatment rendered hereunder by the student doctor, resident, student dental hygienist, faculty or School. The undersigned certifies that he/she has read and is willing to comply with the foregoing, and is the patient, the parent or guardian of the patient with authority to give consent, or is duly authorized by the patient as the patient’s general agent to execute the above and accept its terms. In addition, you acknowledge that you received a copy of the School’s PATIENT BILL OF RIGHTS AND RESPONSIBILITIES.

Patient: ________________________________  Date: __________________________
Witness (Faculty): __________________________
Parent/Guardian: __________________________
Herman Ostrow School of Dentistry of USC Faculty Practice
Medical History Questionnaire

Patient Name: __________________________ Date of Birth: ______________

Reason for visiting the USC Faculty Practice: _________________________

Please answer all questions by checking a box under YES or NO.
Your responses will be held strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concern to a member of our team.

### Cardiovascular:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th></th>
</tr>
</thead>
</table>
|     |    | High blood pressure
|     |    | Heart disease from childhood
|     |    | Heart murmur
|     |    | Rheumatic fever
|     |    | Use of Phen-Fen
|     |    | Pacemaker
|     |    | Vascular graft
|     |    | Heart valve replacement
|     |    | Heart attack
|     |    | Heart surgery
|     |    | Congestive heart failure
|     |    | Angina (chest pain)
|     |    | Irregular heart beat
|     |    | Stroke
|     |    | Increased cholesterol

### Musculo-Skeletal/CNS/Developmental:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th></th>
</tr>
</thead>
</table>
|     |    | Chronic jaw and facial pain
|     |    | Chronic headache pain
|     |    | Chronic neck pain
|     |    | Popping or clicking in your jaw
|     |    | Joint replacement
|     |    | Osteoarthritis
|     |    | Rheumatoid arthritis
|     |    | Spinal cord injury
|     |    | Seizures
|     |    | Dizziness
|     |    | Weakness
|     |    | Multiple Sclerosis
|     |    | Cerebral palsy
|     |    | Intellectual Disability
|     |    | Dementia / Alzheimer's
|     |    | Fainting spells
|     |    | Visual impairment
|     |    | Glaucoma
|     |    | Hearing impairment

### Endocrine/Hematologic/ Oncologic/Immune:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th></th>
</tr>
</thead>
</table>
|     |    | Frequent hunger
|     |    | Frequent thirst
|     |    | Diabetes
|     |    | Thyroid disease
|     |    | Hemophilia
|     |    | Sickle cell disease
|     |    | Bleeding tendency
|     |    | Anemia
|     |    | Cancer
|     |    | Radiation therapy
|     |    | Chemotherapy
|     |    | HIV infection/AIDS
|     |    | Organ transplant
|     |    | Blood transfusion

### Gastro-Intestinal/Genito-Urinary:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th></th>
</tr>
</thead>
</table>
|     |    | Hepatitis (A, B, C, or other?)
|     |    | Kidney dialysis
|     |    | Ulcers
|     |    | Sexually transmitted disease
|     |    | Denied permission to give blood

### Psychological:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th></th>
</tr>
</thead>
</table>
|     |    | Anxiety / Nervousness
|     |    | Depression
|     |    | Mental health treatment
|     |    | Insomnia
Respiratory:
YES NO
☐ ☐ Asthma
☐ ☐ Chronic Sinus Problems
☐ ☐ Night sweats
☐ ☐ Emphysema
☐ ☐ Tuberculosis
Other: ______________________

Social:
YES NO
☐ ☐ Do you use tobacco products?
   If so, how much? ______________
☐ ☐ Do you drink alcohol?
   Every day? ______________
   If so, how much? ______________
☐ ☐ Do you use recreational drugs?

Medication Allergy or Intolerance:
YES NO
☐ ☐ Penicillin
☐ ☐ Dental anesthetic ("Novocain")
☐ ☐ Aspirin
☐ ☐ Codeine
☐ ☐ Latex products
☐ ☐ Iodine
Other: ______________________

Do you have any medical conditions not already mentioned?

______________________________

History of Hospitalization/Surgical Procedures:

______________________________

Family: Did a parent, sibling or child of yours have any of the following?
YES NO
☐ ☐ Diabetes
☐ ☐ High blood pressure
☐ ☐ Heart disease
☐ ☐ Bleeding tendency
☐ ☐ Cancer

To the best of my knowledge, all of the preceding answers are true. If I have any change in my health status, or any change in my medicines, I will inform my dental health care provider at my next appointment.

Patient Signature (or parent/guardian for patients under 18) __________________________
Date __________________________

Dental Practitioner: PRINT name, date, and add signature. ____________________________

FP 05222014
USC PATIENT E-MAIL CONSENT FORM
To address the risks of using e-mail
If you choose to communicate with your Provider by e-mail you must review and consent to the conditions or instructions set forth below.

Email Address: ________________________________

1. RISK OF USING E-MAIL
Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

a. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to intended and unintended recipients.

b. E-mail senders can easily misaddress an e-mail.

c. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.

d. Employers and online services have the right to archive and inspect e-mail transmitted through their systems.

e. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

1. Understand that the content of the e-mail may be monitored by USC to ensure appropriate use.

f. E-mail can be used to introduce viruses into computer systems.

g. E-mail can be used as evidence in court.

h. E-mails may not be secure, including at USC, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. CONDITIONS FOR THE USE OF E-MAIL
Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of e-mail information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a. Although Provider will endeavor to read and respond promptly to an e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient should not use e-mail for medical emergencies or other time sensitive matters.

b. E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via e-mail.

c. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.

d. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling.

e. Provider will not forward patient identifiable e-mails outside of USC healthcare providers without the patient's prior written consent, except as authorized or required by law.

f. The patient should not use e-mail for communication regarding sensitive medical information. According to California law, your provider may not communicate any lab results unless your e-mail correspondence is conducted through a secure server. Additionally, e-mail must never be used for results of testing related to HIV, sexually transmitted disease, hepatitis, drug abuse or presence of malignancy, or for alcohol abuse or mental health issues.

g. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

h. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS
To communicate by e-mail, the patient shall:

a. Avoid use of his/her employer's computer.

b. Put the patient's name in the body of the e-mail. In the body of the message, include your name and your identification number (Medical Record Number) or your date of birth.

c. Key in the topic (e.g., medical question, billing question) in the subject line.

d. Inform Provider of changes in his/her e-mail address.

e. Acknowledge any e-mail received from the Provider.

f. Take precautions to preserve the confidentiality of the e-mail.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by e-mail. If I have any questions I may inquire with my treating physician or the USC Privacy Officer.

Patient Signature: ___________________________ Date: _______________ Time: _______________

Witness Signature: __________________________ Date: _______________ Time: _______________

PATIENT E-MAIL CONSENT FORM

PATIENT ID

12060-1025 (10-11)