Children's Dentistry of Redlands

Welcome to our practice!

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name_____
Nickname_____Sex___
Birthdate_____
Address_____
City_____State_____
Zip Code_____Phone_____
Child lives with_____

Mother ☐ Stepmother ☐ Guardian

Name_____
Home Phone_____
Work Phone_____
SSN_____D.O.B_____
Employer_____

Father ☐Stepfather ☐Guardian

Name_____
Home Phone_____
Work Phone_____
SSN_____D.O.B._____
Employer_____

Parent/Guardian Marital Status

☐Single ☐Married ☐Separated
☐Divorced ☐Widowed

Primary Dental Insurance

Insured's Name_____
Relationship_____
D.O.B._____
SSN/ID_____
Employer_____
Insurance Co._____
Phone _____
GroupNo._____

Secondary Insurance

Insured's Name_____
Relationship_____
D.O.B._____SSN_____
Employer_____
Insurance Co._____
Phone_____
Group No._____

Who makes childs appointments

(Responsible Party)

Name_____
Home Phone_____
Cell Phone_____
Work Phone_____
Best time to call_____
Email Address_____

Emergency Contact(other than parent)

Name _____ Relationship _____
Cell Phone _____

Who may we thank for your referral?_____

Signature_____**Date**_____

Pediatric Medical History

Child's legal name: _____ Preferred name: _____ Date of birth: ____/____/____

Birth sex: ❑ M ❑ F Current gender identity: _____ Pronouns: _____ Race/Ethnicity: _____ Height: ____cm Weight: ____kg

Name/age and relationship of others living in the household: _____

Primary physician: _____ Address/phone: _____ Last visit: _____

Medical specialists: _____ Address/phone: _____ Last visit: _____

Is your child being treated by a physician at this time? Reason _____ ❑ YES ❑ NO

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ❑ YES ❑ NO

List name, dose, frequency & date started: _____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ❑ YES ❑ NO

List date & describe: _____

Has your child ever had a reaction to or problem with an anesthetic? Describe _____ ❑ YES ❑ NO

Have you been told your child needs antibiotics or another medicine before dental treatment? Reason _____ ❑ YES ❑ NO

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____ ❑ YES ❑ NO

Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____ ❑ YES ❑ NO

Is your child up to date on immunizations against childhood diseases? ❑ YES ❑ NO

Is your child immunized against human papilloma virus (HPV)? ❑ YES ❑ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before or at birth, prematurity, inherited conditions, syndromes, or birth defects (such as cleft lip/palate)	❑ YES ❑ NO
Problems with physical growth or development	❑ YES ❑ NO
Sinusitis, chronic adenoid/tonsil infections	❑ YES ❑ NO
Sleep apnea, snoring, or mouth breathing	❑ YES ❑ NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	❑ YES ❑ NO
Irregular heart beat or high blood pressure	❑ YES ❑ NO
Asthma, reactive airway disease, wheezing, or breathing problems	❑ YES ❑ NO
Cystic fibrosis	❑ YES ❑ NO
Frequent colds or coughs, bronchitis, or pneumonia	❑ YES ❑ NO
Frequent exposure to tobacco smoke	❑ YES ❑ NO
Jaundice, hepatitis, or liver problems	❑ YES ❑ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems	❑ YES ❑ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	❑ YES ❑ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder	❑ YES ❑ NO
Bladder or kidney problems or bedwetting	❑ YES ❑ NO
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis	❑ YES ❑ NO
Rash/hives, eczema, or skin problems	❑ YES ❑ NO
Impaired vision, visual processing, hearing, or speech	❑ YES ❑ NO
Developmental disorders, learning problems/delays, or intellectual disability	❑ YES ❑ NO
Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures	❑ YES ❑ NO
Autism/autism spectrum disorder or sensory integration disorder	❑ YES ❑ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness	❑ YES ❑ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)	❑ YES ❑ NO
Attention deficit/hyperactivity disorder (ADD/ADHD)	❑ YES ❑ NO
Behavioral, emotional, communication, or psychiatric problems/treatment	❑ YES ❑ NO
Abuse (physical, psychological, emotional, or sexual) or neglect	❑ YES ❑ NO
Diabetes, hyperglycemia, or hypoglycemia	❑ YES ❑ NO
Precocious puberty or hormonal problems	❑ YES ❑ NO
Thyroid or pituitary problems	❑ YES ❑ NO
Anemia, sickle cell disease/trait, or blood disorder	❑ YES ❑ NO
Hemophilia, bruising easily, or excessive bleeding	❑ YES ❑ NO
Transfusions or receiving blood products	❑ YES ❑ NO
Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant	❑ YES ❑ NO
Corona virus disease 2019 (COVID-19), cytomegalovirus (CMV), human immunodeficiency virus (HIV)/AIDS, methicillin-resistant staphylococcus aureus (MRSA), mononucleosis, scarlet fever, sexually-transmitted disease (STD), or tuberculosis (TB)	❑ YES ❑ NO

PROVIDE DETAILS HERE: _____

Is there any other significant medical history **pertaining to this child or the child's family** that the dentist should be told? ❑ YES ❑ NO

If YES, describe _____

What is your primary concern about your child's oral health? _____

How would you describe:

your child's oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

your oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

the oral health of your other children? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Not applicable

Is there a family history of cavities? ❑ YES ❑ NO If yes, indicate all that apply: ❑ Mother ❑ Father ❑ Brother ❑ Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	❑ YES	❑ NO	_____
Mouth sores or fever blisters	❑ YES	❑ NO	_____
Bad breath	❑ YES	❑ NO	_____
Bleeding gums	❑ YES	❑ NO	_____
Cavities/decayed teeth	❑ YES	❑ NO	_____
Toothache	❑ YES	❑ NO	_____
Injury to teeth, mouth, or jaws	❑ YES	❑ NO	_____
Clinching/grinding teeth	❑ YES	❑ NO	_____
Jaw joint problems (popping, etc.)	❑ YES	❑ NO	_____
Excessive gagging	❑ YES	❑ NO	_____
Sucking habit after one year of age	❑ YES	❑ NO	If YES, how long? _____ Which? ❑ Finger ❑ Thumb ❑ Pacifier ❑ Other_____

How often are your child's teeth brushed? _____ times per _____ Does someone help your child brush? ❑ YES ❑ NO

How often are your child's teeth flossed? ❑ Never ❑ Occasionally ❑ Daily Does someone help your child floss? ❑ YES ❑ NO

What type of toothbrush does your child use? ❑ Hard ❑ Medium ❑ Soft ❑ Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? ❑ City/community supply ❑ Private well ❑ Bottled water

Do you use a water filter at home? ❑ YES ❑ NO If YES, type of filtering system: _____

Please check all sources of fluoride your child receives:

❑ Drinking water ❑ Toothpaste ❑ Over-the-counter rinse ❑ Prescription rinse/gel ❑ Prescription drops/tablets/vitamins

❑ Fluoride treatment in the dental office ❑ Fluoride varnish by pediatrician/other practitioner ❑ Other: _____

Does your child regularly eat 3 meals each day?	❑ YES	❑ NO	
Is your child on a special or restricted diet?	❑ YES	❑ NO	If YES, describe: _____
Is your child a 'picky eater'?	❑ YES	❑ NO	If YES, describe: _____
Does your child have a diet high in sugars or starches?	❑ YES	❑ NO	If YES, describe: _____
Do you have any concerns regarding your child's weight?	❑ YES	❑ NO	If YES, describe: _____

How frequently does your child have the following?

Snacks between meals	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Product _____
Candy or other sweets	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Type _____
Chewing gum	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Usual snack _____
Soft drinks*	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Product _____

(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities?	❑ YES	❑ NO	If YES, list: _____
Does your child wear a mouthguard during these activities?	❑ YES	❑ NO	If YES, type: _____
Has your child been examined or treated by another dentist?	❑ YES	❑ NO	

If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? ❑ YES ❑ NO Date of most recent dental X-rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ❑ YES ❑ NO If YES, when? _____

Has your child ever had a difficult dental appointment? ❑ YES ❑ NO If YES, describe: _____

How do you expect your child will respond to dental treatment? ❑ Very well ❑ Fairly well ❑ Somewhat poorly ❑ Very poorly

Is there anything else we should know before treating your child? ❑ YES ❑ NO

If yes, describe: _____

_____

Signature of parent/guardian	Relationship to child	Date	Signature of staff member reviewing history
_____	_____	_____	_____

MEDICAL/DENTAL HISTORY UPDATE

Is your child being treated by a physician at this time? Reason _____	❑ YES	❑ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?	❑ YES	❑ NO
List name, dose, frequency, & date started: _____		
Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year?	❑ YES	❑ NO
Describe: _____		
Has your child ever had a reaction to or problem with an anesthetic? Describe: _____	❑ YES	❑ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List: _____	❑ YES	❑ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____	❑ YES	❑ NO
Have there recently been any significant changes/disruptions to your child's family, home, or school routines?	❑ YES	❑ NO
Describe: _____		
What is your primary concern regarding your child's oral health? _____		
Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office?	❑ YES	❑ NO
Describe: _____		
Has your child's diet changed significantly since his/her last dental visit? Describe: _____	❑ YES	❑ NO
Has your child been treated by another dentist/dental professional since last visiting our office? Reason: _____	❑ YES	❑ NO
Is there any other change in the child's medical, dental, or family history that the dentist should be told?	❑ YES	❑ NO
Describe: _____		

Signature of parent/guardian	Relationship to child	Date	Signature of staff member reviewing history
_____	_____	_____	_____

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER

Was your child born prematurely? ❑ YES ❑ NO If YES, what week? _____

What was your child's birth weight? _____

How long was your child breastfed? ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

How long was your child bottle-fed? ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

Do/did you feed your child infant formula? ❑ YES ❑ NO If YES, what type? (check one): ❑ Ready to use ❑ Powdered ❑ Liquid concentrate

Does/did your child sleep with a bottle? ❑ YES ❑ NO If YES, content of bottle? _____

Does/did your child use a no-spill training cup (sippy cup)? ❑ YES ❑ NO

Child's age (in months) when first tooth appeared in mouth _____

Has your child experienced any teething problems? ❑ YES ❑ NO

When did you begin brushing your child's teeth? ❑ N/A ❑ before age 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

When did you begin using toothpaste? ❑ N/A ❑ before age 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

Who is your child's primary care taker during the day? _____ during the evening? _____

Name/age of siblings at home: _____

_____

_____ _____ _____ _____

Signature of parent/guardian Relationship to child Date Signature of staff member reviewing history

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT (to be completed by the patient)

For each YES response, please describe:

Do you have any concerns about your mouth, teeth, or oral health? ❑ NO ❑ YES _____

Have you recently experienced any dental/oral pain? ❑ NO ❑ YES _____

Do you have any concerns with the appearance of your teeth or smile? ❑ NO ❑ YES _____

Do you bleach your teeth? ❑ NO ❑ YES _____

Have there been any recent changes in your dietary habits? ❑ NO ❑ YES _____

Are you taking any dietary or herbal supplements? ❑ NO ❑ YES _____

Do you participate in sports or high speed activities (for example skiing, four-wheeling, motorcycling)? ❑ NO ❑ YES _____

We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.

Do you have any history of:

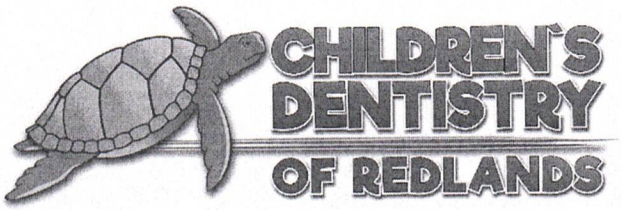
Oral habits (chewing fingernails, clenching/grinding teeth, etc.)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Electronic cigarette (e-cig) use	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Eating disorder (anorexia, bulimia, etc.)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Oral piercings/jewelry (including grill)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Alcohol or recreational drug use/prescription abuse	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Inhalant use/abuse (such as huffing)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Sexual activity (including oral sex)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Abuse (physical, sexual, verbal, mental)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Anxiety, depression, or feeling helpless/hopeless	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Females: Are you pregnant or possibly pregnant?	❑ NO	❑ YES	

Is there anything you would like to discuss confidentially with your dentist? ❑ NO ❑ YES

Would you like to discuss a referral to a family dentist or general dentist because of your age? ❑ NO ❑ YES

_____ _____ _____

Signature of patient Date Signature of staff member reviewing history



OUR FINANCIAL POLICY

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

We will estimate as closely as possible your coverage, but until we actually receive payment from your insurance company, IT IS JUST AN ESTIMATE. All estimates are based on information provided to us by your insurance company and are not a guarantee of payment. We are a non-preferred provider for most PPO insurance plans and this may affect your out of pocket cost.

Non-insured patients are expected to pay in full with cash, check or credit card the day service is rendered.

All returned checks will be subject to a $25.00 returned check fee. Any account balances that remain unpaid for 30 days from the date of service shall accrue interest at the rate of eighteen percent (18%) per month and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of $41.75. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Parent Signature: _____

Print Name: _____

Patient name(s): _____

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)

_____

_____

_____

Children's Dentistry of Redlands

[Insert Name of Practice]

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe 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 applicable law permits the changes. 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 health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses 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 this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may—but are not required to—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 more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. 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.

Provider Contact Office: Children's Dentistry of Redlands

Telephone: 909.793.7274 Fax: 909.793.7781

E-Mail:

Address: 1895 Orange Tree Lane, Suite 202 Redlands, CA 92374