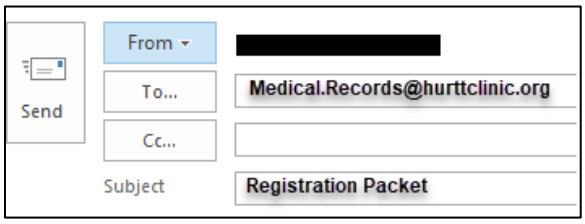
Registration Packet Directions:

For in-clinic appointments:

1. Email the completed and signed registration packet to Medical.Records@hurttclinic.org
   The subject line should say "Registration Packet" see example below.



Or

2. Bring in a completed hard copy of the registration packet to your upcoming appointment.

For Telemed appointments:

1. Email the completed and signed registration packet to Medical.Records@hurttclinic.org
   The subject line should say "Registration Packet" (see previous example).

For ALL pediatric patients the following documents must also be included with the registration packet:

1. Patient's birth certificate.
2. Parents' Identification (Must be valid. Not expired.).

****This registration packet requires the patient to report their household size and income. To complete your registration, please include a copy of the following supporting documentation, **ONE** for each category:*

Government issued identification (not expired):	**Proof of income:**
☐ CA driver license or ID ☐ Consular ID card (CID) ☐ Passport	☐ Paystub ☐ Federal/State Income Tax Form ☐ Wages and Tax Statement (e.g. W-2) ☐ Foreign Income ☐ Self-employment ledger documentations ☐ Bank Statement ☐ Self-Declaration Form ☐ Employer Statement (signed by employer)

HURTT familyhealth CLINIC

Account Number: _____

Patient Registration Form

DOB: _____

Dear Patient: Due to new federal reporting regulations, the following information is now required for each patient. Please note that all information is confidential. We will need to collect this information on an annual basis.

Patient Information

Last Name	**First Name**	**MI**	**Date of Birth**

Address	**Apt./Unit**	**City**	**State**	**Zip Code**

SSN	**Sex** ☐ Male ☐ Female	**Email Address**

Please check primary phone ☐ **Home Phone** ( ) ☐ **Cell Phone** ( ) ☐ **Work Phone** ( )

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Do you need an interpreter: ☐ Yes ☐ No

Race (Please check all that apply):
☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander
☐ Black or African American ☐ White ☐ Other ☐ Decline to Specify

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to Specify

Birth Sex: ☐ Male ☐ Female

Gender Identity: *(How do you identify yourself?)*
☐ Male ☐ Transgender Male/Female-to-Male ☐ Other: _____
☐ Female ☐ Transgender Female/Male-to-Female ☐ Choose Not to Disclose

Sexual Orientation:
☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Don't know ☐ Choose Not to Disclose ☐ Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Health Insurance: ☐ Medicare ☐ Medi-Cal ☐ None ☐ Other: _____

Do you have an Advanced Directive: ☐ Yes ☐ No

Are you a Veteran: ☐ Yes ☐ No

Are you an Agricultural Worker? ☐ Yes ☐ No *If yes, please select a class of work* ☐ Migratory ☐ Seasonal

Are you Homeless: ☐ Yes ☐ No
If yes, please select a living arrangement (Check one):

☐ **Permanent Supportive Housing** (does not have time limits, rent)
☐ **Shelter** (safe havens, temporary overnight housing, armories)
☐ **Transitional** (center, community, home)
☐ **Street** (sidewalk, car, park, doorway, public or abandoned building)
☐ **Doubling Up** (living with other people for a temporary period and move often)
☐ **Other** (hotel, motel, day-to-day single room occupancy)

Are you an OCRM Student: ☐ Yes ☐ No

If yes, select one of the following programs:
☐ Alumni Housing ☐ Hope Family Housing ☐ Pearl House (non-Hurtt) ☐ Sea Glass (Hope Harbor) ☐ Village of Hope
☐ Double R Ranch ☐ House of Hope ☐ Rip Tide (Hope Harbor) ☐ Strong Beginnings

Spouse or Parent/Guardian Information: (If applicable)

Last Name	**First Name**	**Date of Birth**

Please check primary phone ☐ **Home Phone** ( ) ☐ **Cell Phone** ( ) ☐ **Work Phone** ( )

Emergency Contact:

Last Name	**First Name**	**Relation to the Patient**	**Phone Number** ( )

Authorization for Release of Medical Information and Assignment of Benefits

I hereby authorize the release of medical or any other information necessary to my insurance carrier(s), or agent thereof to satisfy claims processing. I also authorize payment of medical benefits to Hurtt Family Health Clinic for services provided. I am financially responsible for payment of services not covered by my insurance.

I have received, read, and agreed to the attached terms and conditions of the Registration Packet and acknowledge that I have filled out the included information to the best of my abilities.

Registration Packet includes the following documents:
Authorization for Treatment *Patient Bill of Rights* *Advance Directive*
HIPAA Notice of Privacy *Patient's Responsibilities* *Additional Consents*

Signature:	Relationship to patient, if not patient:	Date:

HURTT familyhealth CLINIC

Account Number: _____

DOB: _____

Sliding Fee Application

We are a non-profit clinic that provides low cost health care on a sliding scale. Discounts are calculated based on family income and size. It is necessary for us to ask personal questions in order to determine if you qualify for a discount for your visits. If you choose to not complete this documentation you will not be eligible to receive any discount. This information is confidential.

Please check this box and sign this application if you do not wish to be screened for the Sliding Fee Discount Program and are voluntarily choosing to decline the Sliding Fee Discount Program.

By checking this box, you understand that in the event that a rendered service is not covered by your insurance, you will be responsible to pay the full fee associated with you visit.

☐ *I decline the Sliding Fee Scale Discount Program and agree to the statement above.*

Last Name	**First Name**	**Date of Birth**	**SSN**

Employer:	**Occupation:**

Total number of dependents in the Household: _____

Total dependents includes any immediate family members living in the home (i.e. mother/father/children) and any person that lives in the home and mutually contributes to household expenses.

Total gross income: $_____ ☐ Weekly (52) ☐ Bi-Monthly (24) ☐ Monthly (12) ☐ Yearly/Annual (1)

Include income from all dependents in the household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, Veteran's payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.

If no income:

☐ My family has no wages or income. I am not working (receiving salary or wages for work), or receiving unemployment or disability benefits. My income is $0.

This application requires the patient to report their household size and income. To complete your application, please provide your Patient Service representative with a copy of the following supporting documentation for each category:

Government issued identification:

- CA driver license or ID
- Consular ID card (CID)
- Passport

Proof of income:

- Paystub
- Federal/State Income Tax Form
- Wages and Tax Statement (e.g. W-2)
- Foreign Income
- Self-employment ledger documentations
- Bank Statement
- Self-Declaration Form
- Employer Statement (signed by employer)

I certify that the family size and income information shown above is correct. Copies of verifying income may be required before a discount is approved.

Name: _____

Signature: _____ Date: _____

HURTT familyhealth CLINIC

Account Number: _____

Permission to Relay Information

DOB: _____

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information (PHI) be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must provide an alternative address or other method of contacting you.

Hurtt Family Health Clinic will not ask why you are making your request, and will make efforts to accommodate all reasonable requests.

Hurtt Family Health Clinic also utilizes third party entities to disclose certain PHI, including third party medical record coordination, health information exchanges (HIE) with local hospitals and medical providers, and the patient portal.

This request supersedes any prior request for communication of information submitted prior to the date below.

Extended Authorization

Please list any persons you would like to have access to your billing, appointment or health information such as your spouse, caretaker or other family member. This excludes information that is protected under State and Federal law.

Last Name	**First Name**	**Relationship**	**Phone Number** ( )
Last Name	**First Name**	**Relationship**	**Phone Number** ( )
Last Name	**First Name**	**Relationship**	**Phone Number** ( )

If you do not wish to add any extended authorization, please check the box below:

☐ I (the patient) do not authorize to disclose information to anyone (this excludes information that is protected under State and Federal law).

Restrictions on Communication Methods

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below any ways in which you do NOT want to receive communications:

☐ No calls to phone number:	☐ No messages or voice mails left on phone number(s):
☐ No mail to the following address:	

☐ Health Information Exchange (HIE)	☐ 3rd Party Medical Record Coordination	☐ Patient Portal	☐ Other (specify):

_____ _____

Signature (patient/legal representative) Date

If signed by someone other than patient, indicate relationship: _____

Print name: _____

(Legal representative)

Account Number: _____

DOB: _____

Medical Treatment Authorization (Minors)

AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize _____ to consent to any x-ray, examination,
(Full name of an adult into whose care the minor has been entrusted)

immunizations, anesthetic, medical, dental, and mental health services, or surgical diagnosis or treatment and

hospital care of _____ deemed advisable by a license physician and surgeon and
(Full name of the minor)

provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code §6910.

This authorization supersedes any prior request for authorization to treat a minor submitted prior to the date below. It remains in effect until revoked in writing.

_____ _____
Signature (patient/legal representative) Date

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(Patient/legal representative)

HURTT familyhealth CLINIC

Account Number: _____

DOB: _____

Health Questionnaire

Current and Past Health Conditions:

Have you ever had any of the following? Please check box to indicate yes. If none, check here: □ None

Bones and Joints	Now	Past
Arthritis	☐	☐
Fracture or broken bone	☐	☐
Osteoporosis or thinning of the bones	☐	☐

Head, Ears, Eyes, Nose, and Throat	Now	Past
Cataracts or glaucoma	☐	☐
Other vision problems	☐	☐
Hearing problems	☐	☐

Heart and Circulation	Now	Past
Anemia	☐	☐
Bleeding problems	☐	☐
Blood clot	☐	☐
Blood transfusion	☐	☐
Chest pain	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Heart murmur	☐	☐
Heart rhythm problems	☐	☐
High blood pressure	☐	☐

Kidneys and Bladder	Now	Past
Genital problems	☐	☐
Kidney failure	☐	☐
Kidney stones	☐	☐
Other kidney or bladder problems	☐	☐
Urinary tract infection	☐	☐

Lungs	Now	Past
Asthma	☐	☐
Emphysema, chronic lung disease	☐	☐
Pneumonia	☐	☐

Nervous System and Behavior	Now	Past
Depression	☐	☐
Head injury, concussion	☐	☐
Other mental problems	☐	☐
Seizures or epilepsy	☐	☐
Stroke	☐	☐

Skin	Now	Past
Skin Disease	☐	☐

Stomach and Intestine	Now	Past
Gallbladder problems	☐	☐
Hepatitis, other liver disease	☐	☐
Stomach ulcers	☐	☐

Other	Now	Past
Abnormal blood sugar	☐	☐
AIDS or positive HIV test	☐	☐
Cancer	☐	☐
Diabetes (including in pregnancy)	☐	☐
Thyroid gland problem or goiter	☐	☐
Transplant (List type):_____	☐	☐
Tuberculosis or positive TB test	☐	☐
Other (Explain):_____	☐	☐

HURTT familyhealth CLINIC

Account Number: _____

DOB: _____

Health Questionnaire

Please complete this checklist before seeing your doctor or nurse. Your responses will help us provide the best care.

Social History

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

#Children _____ #Miscarriages_____
#Abortions _____

Tobacco Use: ☐ Cigarettes ☐ Snuff ☐ Quit Date: _____
☐ Pipe ☐ Chew ☐ Packs/day _____
☐ Cigar ☐ Never ☐ # of years _____

Caffeine: ☐ Yes ☐ No ☐ Coffee: Cups/day_____
☐ Energy drinks/day _____

Alcohol: ☐ Yes ☐ No ☐ Drinks/day _____
Is alcohol a concern for you/others? ☐ Yes ☐ No

Drug Use:
Have you ever used non-legalized drugs? ☐ Yes ☐ No
Cannabis ☐ Yes ☐ No
Vaping ☐ Yes ☐ No
Have you ever used needles to inject drugs? ☐ Yes ☐ No

Sexual Activity:
Sexually active: ☐ Yes ☐ No ☐ Not currently
Current sex partner ☐ Male ☐ Female
Birth Control method: _____ ☐ Not needed
Have you ever had a sexually transmitted infection (STI)? ☐ Yes ☐ No
Are you interested in being screened for a sexually transmitted infection (STI)? ☐ Yes ☐ No

Surgeries		Type of Surgery	Date Performed
Abdominal	☐ Yes ☐ No		
Appendix	☐ Yes ☐ No		
Breast	☐ Yes ☐ No		
Gall Bladder	☐ Yes ☐ No		
Heart	☐ Yes ☐ No		
Orthopedic	☐ Yes ☐ No		
Prostate	☐ Yes ☐ No		
GYN	☐ Yes ☐ No		
Urologic	☐ Yes ☐ No		
Knee Replacement	☐ Yes ☐ No		
Hip Replacement	☐ Yes ☐ No		
Heart Valve Replacement	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

Past Testing		Date Performed
Bone Density	☐ Yes ☐ No	
Colonoscopy	☐ Yes ☐ No	
EKG	☐ Yes ☐ No	
Mammogram	☐ Yes ☐ No	
PAP Smear (Females)	☐ Yes ☐ No	
Prostate Screening (Males)	☐ Yes ☐ No	
Pulmonary Testing	☐ Yes ☐ No	
Stress Testing	☐ Yes ☐ No	

Other Concerns:

Weight: Is your weight a concern? ☐ Yes ☐ No

Diet: How do you rate your diet?

Exercise:
Do you exercise regularly? ☐ Yes ☐ No
What kind of exercise? _____
How long (minutes) _____
How often? #____/week

Are you currently taking/planning to take bisphosphonates (Osteoporosis /Low Bone mineral density)? ☐ Yes ☐ No

Mental Well-being

Have you felt down, depressed or hopeless during the past month?	☐ Yes ☐ No
Often having little pleasure in doing things during the past month?	☐ Yes ☐ No
Rate your overall stress level	☐ Low ☐ Medium ☐ High

Medication	Dose	Times/Day

Medication	Dose	Times/Day

Pharmacy: What local pharmacy do you use? _____ Location _____

Allergies or reactions: To medication, food, environment, or other agent.

☐ No known allergies or reactions to any medications

Medication, Food, Other	Reaction or Side Effect	Date it Occurred

Family History: ☐ Adopted ☐ Family History Unknown

Family History *Check all that apply*	Mental health Disorder	Alcohol	CANCER					Diabetes	High Blood Pressure	High Cholesterol	Cause of Death	Other
			Breast	Colon	Prostate	Uteri an	Lung					
Father												
Mother												
Maternal Grandfather												
Maternal Grandmother												
Paternal Grandfather												
Paternal Grandmother												
Brothers												
Sisters												

Informing Materials

The following information is for all patients of Hurtt Family Health Clinic

1. Authorization for Treatment
2. HIPAA Notice of Privacy
3. Patient Bill of Rights
4. Patient's Responsibilities
5. Advance Directive
6. Additional Consents

AUTHORIZATION FOR TREATMENT

Medical care is a patient care service in response to a wide range of medical care needs of patients of all ages regardless of gender, color, race, creed, national origin or disability, five days a week. The Hurtt Family Health Clinic uses evidence-based practices to make decisions about treatment and in order to provide high quality healthcare for all patients.
The purpose of medical care is:

1. To treat disease, injury and disability by examination, testing and use of procedures as needed, in the aid of diagnosis or treatment.
2. To obtain information needed in diagnosing and examining patients.
3. To prevent or minimize residual physical and mental disability.
4. To aid patients in achieving their maximum potential within their capabilities.
5. To accelerate convalescence and reduce the length of the functional recovery.

All procedures will be thoroughly explained to you before you are asked to perform them. You are expected to cooperate fully with the examination and stop any test or procedure before experiencing any increase in your current level of pain or discomfort. There are certain inherent risks with medical care; if you have any concerns about your proposed treatment as described by your provider please let them know prior to the examination or procedure. The attending physician or provider will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform. Based on the above information, you agree to cooperate fully and to participate in all medical care procedures and to comply with the plan of care as it is established.

Notice to Patients: For your personal safety, do not use any equipment without a staff member present.

HIPAA NOTICE OF PRIVACY

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.

Uses and disclosures:

1. TREATMENT: We will use and disclose your information to provide, coordinate, or manage your health care and any related services. This could include the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. Another example includes providing information to a physician to who you have been referred to ensure correct information for your diagnosis.
2. PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your information be disclosed to the health plan to obtain approval for the hospital admission.
3. HEALTH CARE OPERATIONS: We may use or disclose, as needed your protected health information in order to support business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to indicate your physician. We may also call you by name in the waiting room and call you to remind you of your appointment.
4. We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health

oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal and military activity, national security, workers compensation, inmates. Required use and disclosures; under law, we must make disclosures to you and when required by the Secretary of the Department of Health & Human Services to investigate or determine our compliance with requirements of Section 164.500.

5. Other permitted and required uses and disclosures will ONLY be made with your written consent, authorization, or opportunity to object unless REQUIRED by LAW. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

I hereby consent to the use and disclosure of all medical data about me or my minor children for uses allowed by law, including for the following purposes:

1. Review by doctors, hospitals, other health care providers and their staff who treat us.
2. Review by insurers, administrators, and others who may pay for the cost of treating us.
3. Review by health care officials when statutes, regulations or professional duty so require.

PATIENT BILL OF RIGHTS

As a patient of Hurtt Family Health Clinic, you have the right, consistent with California law, to:

1. Understand and use these rights, if for any reason you need help with this, we will provide assistance.
2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or sexual orientation.
3. Receive considerate and respectful care in a clean and safe environment.
4. Be informed of the name and position of the health care provider who will be in charge of your care.
5. Know the name, position, and function of any staff involved in your care and refuse treatment, examination, or observation by that person.
6. Receive care in a non-smoking environment.
7. Privacy and confidentiality of all information and records regarding your care.
8. Participate in all decisions about your treatment.
9. Refuse treatment, examination or observation and be told what effect this may have on your health.
10. Obtain a copy of your medical records within a reasonable period of time
11. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
12. Receive all the information you need to give informed consent for any proposed procedure treatment. This information shall include the possible risks and benefits of the procedure or treatment.
13. Receive urgent care if you need it.
14. Complain, without fear of reprisals, about the care and services you are receiving and to have Hurtt Family Health Clinic respond to you, and if you request it, provide you with a written response. If you are not satisfied with the response, Hurtt Family Health Clinic must provide you with the telephone numbers of alternate physicians so that you may transfer your medical care.

PATIENT'S RESPONSIBILITIES

The staff at Hurtt Family Health Clinic strives to provide you, the patient, with the best care possible. Below are some things you can do to help us achieve that goal:

1. Arrive on time for scheduled appointments. If you will not be able to make the appointment please call 24 hours in advance to cancel and reschedule. If you arrive after your scheduled appointment, you may be asked to wait for the next available appointment or to reschedule.
2. Give your health care provider all the information that is needed to determine the best treatment for you; fill out forms completely and accurately.
3. Provide correct and complete contact information.
4. Be open and honest with your health care provider.

5. Call your health care provider promptly if your condition worsens or does not follow the expected course
6. Check with your provider well before you run out of your current supply of medication.
7. Use prescription and over the counter medications as directed. You should never share medication prescribed for you with others.
8. Treat fellow patients at Hurtt Family Health Clinic with the same courtesy and respect that you would expect from them. Please respect others right to privacy as you would ask that your own be respected.
9. Arrive to your appointment sober and prepared. If you arrive or present as under the influence of any illicit substances, you may be asked to leave and reschedule your appointment for another day.

ADVANCE HEALTH CARE DIRECTIVE (AHCD)

An AHCD is a way to make your healthcare wishes known if you are unable to speak for yourself or prefer someone else to speak for you. An AHCD can serve one or both of these functions:

1. Power of Attorney for Health Care (to appoint an agent)
2. Instructions for Health Care (to indicate your wishes)

If you wish to complete an AHCD or would like additional information, please let you Patient Services representative know and you will be provided with an AHCD packet and FAQ sheet.

If you currently have an AHCD, please provide a copy for your medical records as soon as possible.

ADDITIONAL CONSENTS

APPLICABLE LEGAL DOCUMENTS FOR MINORS

For all minor patients (under 18 years of age), legal guardians will be asked to show documentation to prove that a legal relationship exists. This is for both the safety of the child and guardian and to ensure that the legally appointed parent or guardian is responsible for making medical decisions on behalf of the minor. Applicable legal documents pertaining to custody, divorce, separation, adoption or name change of a parent or child are required.

*All minors must have a birth certificate on file before being seen by a provider. *

LIMITED CONSERVATORSHIP

Limited conservatorships are for adults with developmental disabilities who are unable to make medical decision on their own behalf. If a patient is unable to make medical decisions on their own behalf due to a developmental disability, legal documentation appointing the conservator will be required. Proof of conservatorship must be presented at time of registration and before the patient can be seen by a provider. Documentation must include the right of the conservator to consent for medical treatment on behalf of the patient.

CAIR Notice

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's your right to limit who is able to access your records in the California Immunization Registry (CAIR).

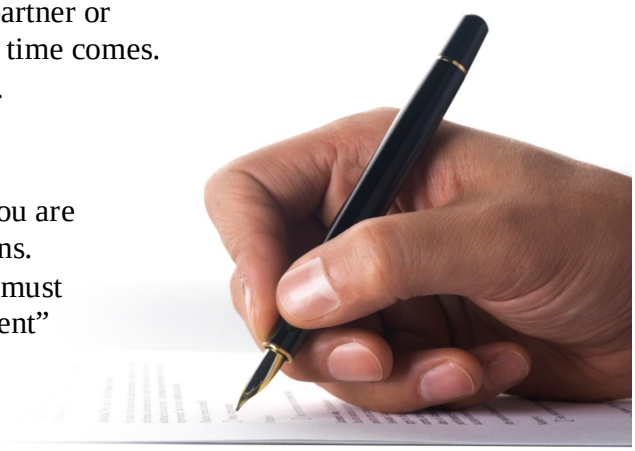
Dental Facts

See attached dental fact sheet.

Advance Directives: What You Need to Know

What Is An Advance Directive?

- An Advance Directive is a document that states in writing your wishes about what type of care you would want or do not want, in case you get hurt, sick or become unable to make medical decisions for yourself.
- On the form, you may choose an adult relative, spouse, partner or friend as your "agent" to make these decisions when the time comes.
- You must sign your name and write the date on the form.



Where Do I Begin?

- You can write or fill out your own advance directive if you are 18 years or older, and are able to make your own decisions.
- You do not need a lawyer to fill out the document, but it must be signed by a notary public or by 2 witnesses. Your "agent" cannot be one of the witnesses.

Choose A Person You Trust.

- After you choose this person, talk to them in detail about what you want. Make sure this person knows your wishes and are willing to make them for you.
- Talk with your doctor and "agent" about what you want and give them both a copy.
- Your doctor may ask you to sign a form that states you have talked to them about this document.

Can I Change My Mind?

- You may change or cancel your advance directive at any time, as long as you are aware of how the choices impact your health care. Being aware means you can still think and voice your wishes in a clear manner. You can also change your "agent."
- Make sure that your doctor and your "agent" know about any changes.

Why Sign One Now When I'm Healthy?

- The best time to sign an advance directive is when you are healthy, and are able to think and speak for yourself. Having a plan in place will ensure that your wishes are followed.

Where Can I Get The Advance Directive Document?

- Most hospital emergency rooms and the Orange County Office on Aging have these forms. Call **1-800-510-2020** for more information. You do not need to use a form. You can also write your wishes down on paper and have this document signed instead.
- Contact Caring Connections at **www.caringinfo.org**.

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an immunization registry to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to limit who is able to access your records in the California Immunization Registry (CAIR).

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children need
- Make sure children meet requirements for shots and TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests or medical exemptions

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number. Health officials can also look at the registry to protect public health.

Patient and Parent Rights

It's your legal right to ask your provider:

- to prevent other providers and schools from accessing your (or your child's) registry records
- not to send shot appointment reminders
- for a copy of your or your child's shot/TB test records
- who has seen the records and to change any mistakes

No action is needed to be part of CAIR. Other CAIR providers, schools, and health officials automatically have access to your or your child's records.

If you want to limit who sees your or your child's records:

1. Check with your provider to see if they can lock your records in CAIR
2. If your provider can't, complete a Request to Lock My CAIR Record form at **CAIRweb.org/cair-forms.**
3. If you change your mind, complete the Request to Unlock My CAIR Record form.
4. Fax printed forms to 1-888-436-8320, or email them to **CAIRHelpDesk@cdph.ca.gov.**

For more information, contact the CAIR Help Desk at 800-578-7889 or **CAIRHelpDesk@cdph.ca.gov**

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 BOARD OF CALIFORNIA
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The Facts About Fillings

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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.

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

Disadvantages

- Material is brittle and can break under biting forces
- May not be recommended for molar teeth
- Higher cost because it requires at least two office visits and laboratory services

NICKEL OR COBALT-CHROME ALLOYS

Nickel or cobalt-chrome alloys are mixtures of nickel and chromium. They are 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

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 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