Medical & Dental Health History

Today's Date: _____

Please complete this form as accurately as possible. Your answers help us provide safe, individualized dental care. We may ask follow-up questions when clarification is needed.

PATIENT INFORMATION

Last Name: _____	First Name: _____	Middle Name/Initial: _____
Preferred Name: _____	Date of Birth: ____ / ____ / _____	
Home Phone: _____	Cell Phone: _____	Work Phone: _____
Email: _____	Occupation: _____	Preferred Contact: ☐ Call ☐ Text ☐ Email
Street Address: _____	City: _____	State: _____ ZIP: _____
Emergency Contact: _____	Relationship: _____	Phone: _____

If another person is completing this form, provide their name, relationship to the patient, and legal authority (if applicable):

_____

DENTAL HISTORY & CURRENT CONCERNS

Reason for today's visit: _____

Current dental pain or discomfort? ☐ Yes ☐ No Location: _____ Pain level (0-10): _____

Last dental exam: ____ / ____ / _____ What was done? _____

Last dental X-rays: ____ / ____ / _____ Last dental cleaning/treatment:_____

Condition / Question	Yes	No	Unsure	Condition / Question	Yes	No	Unsure
Difficulty opening your mouth	☐	☐	☐	Dry mouth or reduced saliva	☐	☐	☐
Pain when chewing, biting, or swallowing	☐	☐	☐	Bad breath or unpleasant taste that persists	☐	☐	☐
Gums bleed during brushing or flossing	☐	☐	☐	Loose teeth or shifting bite	☐	☐	☐
History of deep cleaning or periodontal therapy	☐	☐	☐	Dental treatment makes you anxious or fearful	☐	☐	☐
Sores, ulcers, lumps, or growths in the mouth	☐	☐	☐	Snoring, mouth breathing, or interrupted sleep	☐	☐	☐
Clenching or grinding your teeth	☐	☐	☐	Prior injury to your teeth, jaws, face, or head	☐	☐	☐
Jaw clicking, popping, locking, or pain	☐	☐	☐	Prior difficulty with dental treatment	☐	☐	☐
Frequent headaches, earaches, or neck pain	☐	☐	☐	Reaction or problem with dental anesthetic	☐	☐	☐
Sensitive teeth to hot, cold, sweets, or pressure	☐	☐	☐	Concern about the appearance of your smile	☐	☐	☐

Please explain any dental concerns, injuries, treatment complications, or anesthesia reactions marked above:

_____

_____

MEDICATIONS, SUBSTANCES & SPECIAL CONSIDERATIONS

Mark one answer for each item.

Condition / Question	Yes	No	Unsure	Condition / Question	Yes	No	Unsure
Currently taking prescription medication	☐	☐	☐	Taking hormone replacement therapy	☐	☐	☐
Currently taking over-the-counter medication	☐	☐	☐	Using tobacco or nicotine products	☐	☐	☐
Taking vitamins, herbs, or supplements	☐	☐	☐	Using vaping products	☐	☐	☐
Taking blood-thinning medication or daily aspirin	☐	☐	☐	Using cannabis or other controlled substances	☐	☐	☐
Taking medication for osteoporosis or bone disease	☐	☐	☐	Currently pregnant or possibly pregnant	☐	☐	☐
Receiving or scheduled for IV/injectable bone medication	☐	☐	☐	Currently nursing/breastfeeding	☐	☐	☐

List all medications, vitamins, supplements, and doses (attach a separate list when needed):

_____

_____

Alcohol use: ☐ None ☐ Occasional ☐ Weekly ☐ Daily Approximate drinks per week: _____

Tobacco/nicotine/cannabis details (type, amount, frequency): _____

Medical & Dental Health History

Please complete this form as accurately as possible. Your answers help us provide safe, individualized dental care. We may ask follow-up questions when clarification is needed.

ALLERGIES & ADVERSE REACTIONS

Mark Yes, No, or Unsure. Describe every "Yes" response.

Condition / Question	Yes	No	Unsure	Condition / Question	Yes	No	Unsure
Penicillin or other antibiotics	☐	☐	☐	Metals or jewelry	☐	☐	☐
Sulfa medications	☐	☐	☐	Iodine or contrast dye	☐	☐	☐
Aspirin or NSAIDs	☐	☐	☐	Adhesives or tape	☐	☐	☐
Codeine, opioids, or other pain medication	☐	☐	☐	Food allergy	☐	☐	☐
Sedatives or sleeping medication	☐	☐	☐	Seasonal/environmental allergy	☐	☐	☐
Local anesthetics / numbing medication	☐	☐	☐	Other medication or substance allergy	☐	☐	☐
Latex or rubber	☐	☐	☐				

Describe the allergen, reaction, severity, and approximate date. Include any emergency treatment required:

_____

_____

_____

GENERAL MEDICAL & SURGICAL HISTORY

Primary Care Physician: _____	Phone: _____
Date of last physical exam: ____ / ____ / _____	Usual blood pressure: _____ / _____
Preferred Pharmacy: _____	Phone: _____

Condition / Question	Yes	No	Unsure
You consider yourself in good general health	☐	☐	☐
Currently under the care of a physician or specialist	☐	☐	☐
A provider advised antibiotics before dental treatment	☐	☐	☐
Serious illness, surgery, or hospitalization within 5 years	☐	☐	☐
Joint replacement (hip, knee, shoulder, etc.)	☐	☐	☐
Heart valve replacement or heart surgery	☐	☐	☐
Organ, bone marrow, or stem-cell transplant	☐	☐	☐
History of difficult bleeding or poor healing	☐	☐	☐
Currently receiving chemotherapy, radiation, or immunotherapy	☐	☐	☐
Recent fever or contagious illness	☐	☐	☐
Need assistance transferring to or from the dental chair	☐	☐	☐
Require accommodations for communication, mobility, or sensory needs	☐	☐	☐

Explain all "Yes" or "Unsure" responses, including dates, treating providers, and current status:

_____

_____

_____

MEDICAL CONDITIONS

Check Yes, No, or Unsure for each condition.

Condition / Question	Yes	No	Unsure	Condition / Question	Yes	No	Unsure	Condition / Question	Yes	No	Unsure
Pacemaker or implanted defibrillator	☐	☐	☐	Tuberculosis or TB exposure	☐	☐	☐	Fainting or dizziness	☐	☐	☐
Artificial/prosthetic heart valve	☐	☐	☐	Anemia	☐	☐	☐	Anxiety	☐	☐	☐
History of infective endocarditis	☐	☐	☐	Bleeding or clotting disorder	☐	☐	☐	Depression	☐	☐	☐
Congenital heart condition	☐	☐	☐	Blood transfusion	☐	☐	☐	Other mental health condition	☐	☐	☐
Coronary artery disease or angina	☐	☐	☐	Cancer	☐	☐	☐	HIV/AIDS or immune deficiency	☐	☐	☐
Congestive heart failure	☐	☐	☐	Diabetes	☐	☐	☐	Autoimmune disease (including lupus)	☐	☐	☐
Heart attack	☐	☐	☐	Thyroid disorder	☐	☐	☐	Arthritis or rheumatoid arthritis	☐	☐	☐
Heart murmur or rhythm disorder	☐	☐	☐	Kidney disease	☐	☐	☐	Osteoporosis	☐	☐	☐
High or low blood pressure	☐	☐	☐	Liver disease, hepatitis, or jaundice	☐	☐	☐	Chronic pain condition	☐	☐	☐
Stroke or transient ischemic attack (TIA)	☐	☐	☐	Gastroesophageal reflux (GERD)	☐	☐	☐	Glaucoma or significant eye disease	☐	☐	☐
Asthma	☐	☐	☐	Stomach or intestinal disease	☐	☐	☐	Frequent or serious infections	☐	☐	☐
COPD, emphysema, or chronic bronchitis	☐	☐	☐	Seizures or epilepsy	☐	☐	☐	Eating disorder or malnutrition	☐	☐	☐
Sleep apnea or other breathing disorder	☐	☐	☐	Neurologic disorder	☐	☐	☐				

Medical & Dental Health History

Please complete this form as accurately as possible. Your answers help us provide safe, individualized dental care. We may ask follow-up questions when clarification is needed.

RECENT SYMPTOMS During the past 30 days, have you experienced any of the following?

Condition / Question	Yes	No	Unsure	Condition / Question	Yes	No	Unsure
Chest pain, pressure, or tightness	☐	☐	☐	Fever without a known reason	☐	☐	☐
Shortness of breath or difficulty catching your breath	☐	☐	☐	Night sweats, chills, vomiting, or diarrhea	☐	☐	☐
Rapid or irregular heartbeat	☐	☐	☐	New or worsening vision changes	☐	☐	☐
Unexplained fainting or loss of consciousness	☐	☐	☐	Severe headaches or migraines	☐	☐	☐
Cough lasting longer than three weeks	☐	☐	☐	Unusual bleeding or bruising	☐	☐	☐
Coughing up blood	☐	☐	☐	Exposure to a contagious disease	☐	☐	☐

Please explain any "Yes" responses and note whether you have been medically evaluated:

_____

_____

_____

ADDITIONAL HEALTH INFORMATION

Height: _____ Weight: _____ Preferred language: _____

Do you have an advance directive or legal healthcare representative? ☐ Yes ☐ No ☐ Unsure

Name of representative (if applicable): _____ Phone: _____

Is there anything else about your health, medications, past treatment, or personal needs that we should know?

_____

_____

PATIENT ACKNOWLEDGMENT & AUTHORIZATION

I confirm that the information provided on this form is complete and accurate to the best of my knowledge. I understand that my medical and dental history may affect diagnosis, treatment planning, medication selection, anesthesia, and healing. I agree to inform Areto Dental of any changes in my health, medications, allergies, pregnancy status, or treating physicians. I authorize the dental team to discuss relevant health information with my healthcare providers when reasonably necessary for safe dental care, subject to applicable privacy laws.

Patient/Legal Guardian Name (print): _____

Signature: _____ Date: ____ / ____ / _____

Relationship to patient (if not the patient): _____

FOR CLINICAL USE ONLY

Medical alerts: ☐ None ☐ Allergy ☐ Bleeding risk ☐ Premedication ☐ Pregnancy ☐ Other: _____

Vital signs: BP _____ / _____ Pulse _____ Resp. _____ SpO_2 _____% Temperature _____ °F

ASA classification: ☐ I ☐ II ☐ III ☐ IV Medical consultation needed? ☐ No ☐ Yes

Clinical comments: _____

_____

Reviewed by: _____ Date: ____ / ____ / _____

ARETO DENTAL | Confidential Patient Health Information

ARETO DENTAL

Use and Disclosure of Health Information Consent Form

Please read the following statement carefully.

Guest name _____ **Responsible party if different** _____ **Relationship to guest** _____

PURPOSE OF THIS CONSENT

By signing this form, you will consent to our use and disclosure of your protected health information, including x-rays, photographs, and videos, to carry out treatment, payment activities, clinical review and training, and healthcare operations.

NOTICE OF PRIVACY PRACTICES

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment practices, clinical review and training, and healthcare operations, of the uses and disclosures we may make of your protected healthcare operations, and of other important matters about your protected health information. A copy of this notice is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice at any time by contacting our office.

RIGHT TO REVOKE

You will have the right to revoke this Consent at any time by giving us written notice of your revocation of this Consent. Your revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. We may decline to treat you or continue treating you if you revoke this Consent.

CONSENT

By signing this consent form, you have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, clinical review and training, and healthcare operations.

Signature _____ **Date** _____

ARETO DENTAL

Dental Consent Form

You have the right to accept or reject dental treatment recommended by Dr. _____ (the "Dentist"). This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatments, or the option of no treatment.

It is very important that you provide the Dentist with an accurate medical history before, during, and after treatment. It is equally important that you follow the Dentist's recommendations and advice regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled follow-up appointments. If you fail to follow the advice of the Dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. Do not sign this form or agree to treatment until you have read, understood, and accepted each item carefully. Be certain the Dentist has addressed all of your concerns to your satisfaction before commencing treatment.

1. DENTAL CARE

The following care may be provided to you during your course of treatment:

Examinations and X-Rays. Radiographs are required to complete your examination, diagnosis, and treatment plan. A periodic examination will be provided by the Dentist at routine cleanings to evaluate your teeth for decay, gum disease, oral cancer, and overall health. The Dentist will read and diagnose any X-rays taken.

Dental Prophylaxis (Cleaning). A routine dental prophylaxis involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur; however, should it persist or if it is severe in nature, the office should be contacted.

Restorations (Fillings). A more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure that can only be found during preparation of the tooth. This may lead to root canal, crown, or both. Sensitivity is a common aftereffect of a newly placed filling. Occasionally after receiving a filling, it may feel high and you may need to return to have the bite adjusted.

Periodontal Treatment. Periodontal disease is an infection causing gum inflammation and/or bone loss that can lead to tooth loss. At times when a routine cleaning is scheduled, the dental hygienist and Dentist may discover periodontal disease is present in all or certain areas of your mouth. If you present with an infection during your routine cleaning appointment, it may be necessary for more extensive treatment to be performed. The dental hygienist may stop the routine cleaning and explain to you alternative treatment plans including nonsurgical cleaning below the gum line, placement of an antibiotic below the gum line, or a gross debridement (two-part cleaning). If further treatment such as gum surgery and/or extractions are necessary, a comprehensive periodontal exam will be scheduled with our periodontist. The success of any periodontal treatment depends in part on your efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products, and follow any other recommendations. Some bleeding after deep cleanings or scaling under the gum line can occur; however, should it persist or if it is severe in nature, the office should be contacted. Untreated periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

Crowns, Bridges, and Veneers. It is not always possible to match the color of natural teeth exactly with artificial teeth. A temporary crown will be made after the initial preparation appointment. Temporary crowns may come off and you should be careful eating on them until the permanent crowns are delivered. If a temporary crown should fall off, call the office immediately. The final opportunity to make changes on crowns, bridges, or veneers (including shape, fit, size, placement, and color) will be done before permanent cementation. In some cases, crowns, bridges, and/or veneer procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. After a crown, bridge, or veneer is permanently cemented, sometimes your bite may feel high and you may need to return to have the bite adjusted or fixed. Modification of daily cleansing procedures may be required, and if so, will be explained to you by the provider.

Temporomandibular Joint Dysfunction (TMD). Symptoms of popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment when the mouth is held in the open position. However, symptoms of TMD associated with dental treatment are usually temporary in nature and well tolerated by most patients. If the need for treatment should arise, you will be referred to a specialist, the cost of which is your responsibility.

2. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common is root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

3. ALLERGIES / MEDICATION

I have informed the Dentist of any known allergies I may have. I understand that antibiotics, analgesics, and other medications can cause allergic reactions including redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may allow tissue discomfort, aggravate infection or pain, or negatively affect the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

4. CONSENT

I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure. I also understand that, regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

Patient signature	Print name	Date
_____	_____	_____
Parent/guardian signature	Print name	Date
_____	_____	_____

ARETO DENTAL

Financial Policy and Patient Agreement

Thank you for choosing Areto Dental. We are committed to providing high-quality dental care and making our financial policies clear and understandable. Please review this agreement carefully and ask us about anything you do not understand before signing.

1. Self-Pay Practice

Areto Dental is currently a self-pay dental practice and does not submit claims to dental insurance companies.

Payment for services is the responsibility of the patient, parent, legal guardian, or other financially responsible party. Payment is due according to the terms described in this policy, regardless of whether the patient has dental insurance or may independently seek reimbursement from another source.

Upon request, Areto Dental may provide an itemized receipt or other documentation that the patient may submit independently to an insurance company. Areto Dental does not guarantee that any insurance company will reimburse the patient.

2. Payment Responsibility

Payment is due at the time services are provided unless a written payment arrangement has been approved by Areto Dental before treatment begins.

- Examinations, consultations, and diagnostic services
- X-rays, photographs, scans, and other records
- Preventive, restorative, surgical, cosmetic, and emergency treatment
- Laboratory fees, medications, materials, appliances, and dental devices
- Missed appointments or late cancellations, when applicable
- Returned payments, collection costs, and other authorized charges

Accepted forms of payment may include cash, debit card, credit card, health savings account, flexible spending account, or approved third-party financing.

3. Treatment Estimates

Before treatment, Areto Dental will make reasonable efforts to provide a written estimate of expected charges.

A treatment estimate is not a guarantee of the final cost. During treatment, the dentist may discover additional conditions that were not visible or known during the initial examination. The patient will be informed of significant changes whenever reasonably possible before additional treatment is performed.

The patient remains responsible for the cost of all services that are authorized and provided.

4. Deposits and Advance Payments

Areto Dental may require a deposit or full payment in advance for certain services, including laboratory-fabricated items, implants, bone grafting, clear aligners, cosmetic procedures, sedation, surgery, or appointments requiring extended clinical time.

Deposits may be applied toward laboratory fees, reserved appointment time, materials, or other treatment-related expenses. Unless otherwise stated in writing, a deposit is not refundable after laboratory work has been ordered, custom materials have been fabricated, or treatment has begun.

5. Payment Plans and Financing

Any payment plan must be approved in writing before treatment begins. Approval is at the discretion of Areto Dental and may require a down payment, valid payment card on file, automatic scheduled payments, third-party financing approval, or full payment by a specified date.

Failure to make payments as agreed may result in cancellation of future non-emergency appointments and referral of the unpaid balance for collection.

6. Credit or Debit Card on File

When permitted by the patient, Areto Dental may securely maintain a payment card on file for authorized charges.

The card will not be charged without authorization except when the patient has signed a separate recurring-payment, payment-plan, missed-appointment, or other payment authorization.

The patient is responsible for notifying Areto Dental if the card expires, is replaced, or is no longer valid.

7. Missed Appointments and Late Cancellations

Appointments are reserved specifically for each patient. Missed appointments and late cancellations limit our ability to provide care to other patients.

We request at least _____ hours' notice when canceling or rescheduling an appointment.

A fee of $_____ may be charged for failure to attend a scheduled appointment, cancellation with less than the required notice, arriving too late for treatment to be completed safely or properly, or repeatedly rescheduling with insufficient notice.

For extended, surgical, sedation, cosmetic, or laboratory-related appointments, a different cancellation fee or loss of deposit may apply.

The fee may be waived at the discretion of Areto Dental for documented emergencies or circumstances beyond the patient's reasonable control.

Repeated missed appointments or late cancellations may result in restrictions on future scheduling, a requirement for advance payment, or dismissal from the practice after appropriate notice.

8. Late Arrivals

Patients who arrive late may receive shortened treatment, may need to reschedule, or may be charged a late-cancellation fee if there is not enough time to complete treatment safely.

Areto Dental will make reasonable efforts to accommodate late arrivals but cannot guarantee that the scheduled procedure can be completed.

9. Returned or Reversed Payments

A fee of $_____ may be charged for any returned check, declined electronic payment, disputed charge, reversed payment, or unsuccessful scheduled payment, to the extent permitted by law.

The patient remains responsible for the original balance and any applicable fees. After a returned or reversed payment, Areto Dental may require future payments to be made by cash, certified funds, debit card, credit card, or another approved method.

10. Outstanding Balances

Any balance not paid when due is considered past due unless a written payment arrangement is in place.

Areto Dental may provide statements, telephone calls, text messages, emails, or other lawful communications regarding an outstanding balance. Patients are responsible for keeping their mailing address, telephone number, and email address current.

Non-emergency treatment may be postponed or discontinued when an account has a past-due balance, subject to the dentist's professional judgment and applicable law.

11. Collections Policy

If an account remains unpaid, Areto Dental may take reasonable steps to collect the balance, including sending payment reminders, contacting the financially responsible party, offering or enforcing an approved payment arrangement, referring the account to a collection agency or attorney, or pursuing other lawful collection remedies.

To the extent permitted by law and by any separate agreement, the patient or financially responsible party may be responsible for reasonable collection costs, agency fees, attorney fees, court costs, and other expenses incurred in collecting the unpaid balance.

Only the minimum necessary information may be disclosed for payment and collection purposes, consistent with applicable privacy laws.

12. Billing Questions or Disputes

Patients should contact Areto Dental promptly with questions about a charge or account balance.

A billing question or dispute does not automatically delay the payment due date. Any undisputed portion of the balance remains due. Chargebacks or payment disputes should not be used as a substitute for first contacting the office to address a billing concern.

13. Refunds and Account Credits

Any approved refund will be processed after the account has been reviewed and all completed services, laboratory charges, materials, financing fees, and other applicable expenses have been accounted for.

Refunds will generally be issued to the original form of payment when possible. Unused account credits may be applied to future treatment or refunded in accordance with office policy and applicable law.

14. Minors and Dependent Patients

The parent, legal guardian, or adult who authorizes treatment for a minor is responsible for payment unless Areto Dental has accepted a different written financial arrangement in advance.

Divorce agreements, custody orders, or private arrangements between parents do not change the responsible party's obligation to Areto Dental unless the practice has agreed otherwise in writing.

15. Emergency Treatment

Emergency evaluation and treatment may require payment at the time of service. When ongoing treatment is recommended after an emergency visit, the patient will receive information about expected charges and available payment options.

16. Changes to This Policy

Areto Dental may update its financial policies from time to time. Any updated policy will apply to future services after the patient has been given notice. Changes will not alter payment obligations for services already provided.

ACKNOWLEDGMENT AND AGREEMENT

By signing below, I acknowledge that:

- I have read and understand this Financial Policy and Patient Agreement.
- I have had the opportunity to ask questions.
- I understand that Areto Dental is currently a self-pay practice and does not submit insurance claims.

- I accept financial responsibility for all services provided to me or to the patient named below.
- I understand the missed-appointment, late-cancellation, returned-payment, and collections policies.
- I agree to pay all amounts due according to this agreement and any treatment-specific financial arrangement I sign.

Patient name	**Date of birth**	**Relationship to patient**
Financially responsible party	**Signature**	**Date**
Areto Dental representative	**Signature**	**Date**

ARETO DENTAL

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.

GENERAL INFORMATION

Our Legal Duty. We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect June 1, 2026and will remain in effect until we replace it.

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

Copies and Information. 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.

Your Authorization. In addition to our use of your health information for the following purposes, 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 use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Security. You will be notified as soon as possible if the security of your personal health information is breached.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you without authorization for the following purposes. Please note: We do not create or maintain any SUD or psychotherapy notes at this practice, including any records from Part 2 Programs. Therefore, in no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order. We also recognize that some information, such as HIV-related information, genetic information, any alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. Therefore, if we receive these records from another provider, we will handle them in accordance with all legal requirements.

Treatment. We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician, pharmacist, or other healthcare provider providing treatment to you.

Payment. We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

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

To You or Your Personal Representative. We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care. We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services. We will not use your health information for marketing communications without your written authorization. We will not use your information for fundraising purposes without authorization. We will disclose any financial conflicts of interest that may be involved with your treatment.

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

Public Health and Public Benefit. We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents. We may disclose health information about a decedent as authorized or required by law.

National Security or Disaster Relief. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence, and other national

security activities. We may disclose correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances. We may use or disclose your health information to assist in disaster relief efforts.

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

YOUR RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.25 for each page to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting. You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction. You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

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

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Non-disclosure to insurance company. If you pay out of pocket, in full, for a service or a procedure or service; we will not submit the claim for that service to your insurance company upon your request.

Electronic Notice. You may receive a paper copy of this notice upon request.

QUESTIONS AND COMPLAINTS

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ARETO DENTAL

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that Areto Dental has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below for a current copy of the Notice of Privacy Practices document.

COMMUNICATION PERMISSIONS

Permission	Yes	No
Leave a message on your answering machine?		
Confirm appointments by leaving messages or speaking with family?		
Leave pre-medication reminders (if applicable)?		
Speak to household members concerning your care?		

Patient name _____ **Signature** _____ **Date** _____

Name / relationship to patient _____ **Signature** _____ **Date** _____

FOR OFFICE USE ONLY

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

■ Patient or guardian refused to sign ■ Emergency situation

■ Other: _____