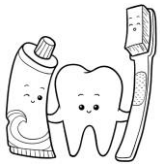

WELCOME
to ERRINGER FAMILY DENTAL GROUP!

Today's Date: _____

Registration Information for a Dependent:

Patient Name: _____
Title Last First MI Suffix

Preferred Name: _____ Social Security #: __ __ __ - __ __ - __ __ __ __

Birthdate: __ __ / __ __ / __ __ __ __ **Sex:** □ Male □ Female

Phone (Home): _____ (Cell): _____

Home Address: _____
Street City State Zip

Name of Parent or Guardian: _____ **Sex:** □ Male □ Female
Last First MI

Emergency Contact Name & Phone #: _____
Name Phone #

Other members of your immediate family who are patients in our office: _____

_____

Responsible Party Information:

Name: _____ □ Male □ Female Relationship to Patient: _____
Last First

Address: _____
Street City State Zip

Soc Sec #: __ __ __ - __ __ - __ __ __ __ Birthdate: __ __ / __ __ / __ __ __ __

Phone (Home): _____ (Cell): _____

Email Address: _____ **Preferred Method of Contact:** □ Call □ Text □ Email □ Mail

Employer Name: _____ **Marital Status:** □ Married □ Single □ Widowed

Work Phone Number: _____ □ Primary Insurance holder □ Secondary Insurance Holder

Appointment Policy:

We require **24 hours notice** for appointment cancellations. Appointment changes made without adequate notice will be charged a fee of **$55 per hour**, payable by the patient and not the insurance company.

Insurance Information:

Primary Insurance Policy

Name of Policy Holder: _____ **Policy Holder's Date of Birth:** _____

Is the Policy Holder a patient? □ Yes □ No **Policy Holder's Employer:** _____

Policy Holder's ID # _____ **Group #** _____

Patient's Relationship to the Policy Holder: □ Self □ Spouse □ Child □ Other _____

Dental Insurance Company Name: _____ **Phone #:** _____

Secondary Insurance Policy

Name of Policy Holder: _____ **Policy Holder's Date of Birth:** _____

Is the Policy Holder a patient? □ Yes □ No **Policy Holder's Employer:** _____

Policy Holder's ID # _____ **Group #** _____

Patient's Relationship to the Policy Holder: □ Self □ Spouse □ Child □ Other _____

Dental Insurance Company Name: _____ **Phone #:** _____

Please be aware that we collect estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of insurance benefit. As a courtesy to you, we will file your claims with your insurance company. Insurance payments are normally received within 30 to 45 days. **Any unpaid balances, after insurance payment has been applied, are your responsibility and are due at that time. All deductibles and co-payments are due at the time of service.** A completed claim form or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance company; however, you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office.

Assignment of Benefits: Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Andrew Mahler, DDS of the insurance benefits otherwise payable to me.

X Signature of patient, parent, or guardian: _____ **Date:** _____

Billing Policy, Consent for Treatment and Payment:

Payment is expected at time of service. We accept cash, check, Visa, Discover, MasterCard, American Express, and Care Credit. Returned checks are subject to a $25.00 fee. Aged balances over 60 days, regardless of insurance, are subject to a billing charge of $2.00 per month and/or finance charges of 21.0% A.P.R. Balances not paid within ten days of the due-date are subject to a late fee of 5% or $15.00 per service date. A past-due balance is any amount owing from a prior visit where an insurance payment has not been received by us within 60 days. If you have a past-due balance and wish to receive service, you will be required to pay the past-due balance and the new charges at time of service.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for and by members of my family shown by statements, promptly upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family or me I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that all payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I hereby acknowledge receipt of a copy of this form.

X Signature: _____ **Date:** _____

Acknowledgement of receipt of Notice of Privacy Practices (HIPAA):

You may refuse to sign this acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices and consent to the healthcare operations it describes.

Print the Name of the Patient or Personal Representative: _____

X Signature of Patient or Personal Representative: _____ Relationship to Patient: _____

Comprehensive Exam Dental Questionnaire

Name: _____ Date: _____

Dental Treatment Questions:

Previous Dental Experience:

1. Do you feel nervous about having dental treatment? □ Yes □ No
2. Have you ever had an upsetting dental experience? □ Yes □ No
3. Do you want to discuss "Dental Doula" options? □ Yes □ No

Satisfaction with Your Teeth:

4. Have you been treated with Orthodontics in the past? □ Yes □ No
5. Do you want straighter teeth? □ Yes □ No
6. Are you satisfied with the appearance of your teeth? □ Yes □ No
7. Have you noticed any spots or stains on your teeth that concern you? □ Yes □ No
8. If you could have your teeth whitened, would you be interested? □ Yes □ No
9. Are there old fillings or dental work you would like to change? □ Yes □ No
10. Have you noticed any loose teeth or change in your bite? □ Yes □ No

Have You Ever Had:

11. Periodontal treatment? □ Yes □ No
12. Oral Surgery? □ Yes □ No
13. Your teeth ground or your bite adjusted? □ Yes □ No
14. An oral cancer exam? □ Yes □ No
15. A serious injury to the mouth or head? □ Yes □ No

Do You:

16. Have areas that are difficult to floss? □ Yes □ No
17. Have areas where food catches between your teeth? □ Yes □ No
18. Snore or have any other sleeping disorders? □ Yes □ No
19. Wake up in the morning still feeling tired? □ Yes □ No
20. Have tired jaws, especially in the morning? □ Yes □ No
21. Clench or grind your teeth while awake or asleep? □ Yes □ No
22. Bite your lips or cheeks regularly? □ Yes □ No
23. Hold foreign objects (pencils, pipe, etc.) with your teeth? □ Yes □ No
24. Wear removable dentures or partial dentures? □ Yes □ No
25. Use any other dental devices (i.e. retainer, bite guard, snoring appliance)? □ Yes □ No
26. Mouth-breathe while asleep or awake? □ Yes □ No
27. Have an unpleasant taste in your mouth or bad breath? □ Yes □ No
28. Smoke/vape/chew tobacco products? □ Yes □ No

Have You Ever Experienced:

29. Clicking or popping of your jaw? .... □ Yes □ No
30. Pain (joint, ear, side of face)?..... .... □ Yes □ No
31. Difficulty in opening or closing your mouth?..... .... □ Yes □ No
32. Difficulty chewing on either side of your mouth? .... □ Yes □ No
33. Headaches, neck aches, or shoulder aches?..... .... □ Yes □ No
34. Sore muscles (neck, shoulders)? .... □ Yes □ No
35. Frequent cold sores, blisters, or other lesions? ... . □ Yes □ No

Are Any of Your Teeth Sensitive to:

36. Hot, cold, or sweets?..... .... □ Yes □ No
37. Biting or chewing?..... .... □ Yes □ No

Dental Hygiene Questions:

38. Date of last dental cleaning? _____ Date of last Full Mouth X-Rays: _____

    ..... What was the name of the office or dentist? _____

39. How often do you brush? _____

40. What do you use to clean your teeth/gums?

□ Manual Toothbrush	□ Floss	□ Toothpick	□ Water pick
□ Electric Toothbrush	□ Fluoride Rinse	□ Tongue Blade	

41. Have you ever been told that you have periodontal disease?..... .... □ Yes □ No
42. Have your **parents** experienced gum disease or tooth loss?..... .... □ Yes □ No
43. Have you ever had a deep cleaning? .... □ Yes □ No
44. Do your gums bleed when brushing/flossing? .... □ Yes □ No
45. Are you currently using any prescription toothpaste or mouthwash? .... □ Yes □ No

    .....If so, what? _____

46. Have you been told to take a pre-medication prior to dental treatment? . ... □ Yes □ No
47. Do you have any other dental problems or concerns that we should know about?..... □ Yes □ No

    .....If so, what? _____

Medical History

Patient's Name: _____ Birthdate: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's name: _____ Phone: _____

1. Have you had any medical care within the past 2 years? .....□ Yes □ No
2. Have you taken any medication or drugs during the past 2 years? .....□ Yes □ No
3. Are you currently taking any medication, drugs, pills, or herbal remedies, including regular dosages of Aspirin? .....□ Yes □ No
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Bovina, or other bisphosphonates? .....□ Yes □ No
5. Have you or do you plan on receiving a COVID-19 vaccine? .....□ Yes □ No
6. Are you aware of having an **allergic or adverse reaction** to any of the following?

□ Penicillin	□ Erythromycin	□ Acrylic	□ Latex
□Dental Anesthetics	□ Tetracycline	□ Metal	□ Codeine
□ Sulfa	□ Aspirin	□ Other:	

7. Have you been a patient in the hospital during the past 5 years? .....□ Yes □ No
8. Have you lost or gained more than 10 pounds in the past year? .....□ Yes □ No

Women – Are you:

Pregnant/Trying to get pregnant? □ Yes □ No Taking oral contraceptives? □ Yes □ No Nursing? □ Yes □ No

9. Indicate which of the following **HEART CONDITIONS** you have had, or have at present:

Angina	□ Yes □ No
Artificial Heart Valve	□ Yes □ No
Congenital Heart Disorder	□ Yes □ No
Heart Attack/ Failure	□ Yes □ No
Heart Murmur	□ Yes □ No
Heart Pacemaker	□ Yes □ No
Heart Trouble/ Disease	□ Yes □ No
Irregular Heartbeat	□ Yes □ No
Mitral Valve Prolapse	□ Yes □ No

10. Indicate which of the following **MEDICAL CONDITIONS** you have had, or have at present:

AIDS/HIV Positive	□ Yes □ No	Diabetes	□ Yes □ No	Latex Sensitivity	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Diet/ Recent Weight Loss	□ Yes □ No	Liver Disease/ Yellow Jaundice	□ Yes □ No
Anaphylaxis	□ Yes □ No	Diuretic	□ Yes □ No	Low Blood Pressure	□ Yes □ No
Anemia	□ Yes □ No	Emphysema	□ Yes □ No	Neurological Disorders	□ Yes □ No
Anxiety/ Nervousness	□ Yes □ No	Epilepsy or Seizures	□ Yes □ No	Pain in Jaw Joints	□ Yes □ No
Arthritis/Gout	□ Yes □ No	Excessive Bleeding	□ Yes □ No	Psychiatric Care	□ Yes □ No
Artificial Joint	□ Yes □ No	Fainting Spells/ Dizziness	□ Yes □ No	Radiation Treatments	□ Yes □ No
Asthma	□ Yes □ No	Frequent Cough	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Blood Transfusion	□ Yes □ No	Glaucoma	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
Breathing Problem	□ Yes □ No	Hay Fever	□ Yes □ No	Sinus Trouble	□ Yes □ No
Bruise Easily	□ Yes □ No	Hemophilia	□ Yes □ No	Stroke	□ Yes □ No
Cancer	□ Yes □ No	Hepatitis A	□ Yes □ No	Swelling of Limbs	□ Yes □ No
Chemotherapy	□ Yes □ No	Hepatitis B or C	□ Yes □ No	Thyroid Disease	□ Yes □ No
Chest Pains	□ Yes □ No	High Blood Pressure	□ Yes □ No	Tuberculosis	□ Yes □ No
Cold Sores/ Fever Blisters	□ Yes □ No	High Cholesterol	□ Yes □ No	Tumors or Growths	□ Yes □ No
Contact Lenses	□ Yes □ No	Hives or Rash	□ Yes □ No	Ulcers	□ Yes □ No
Cortisone Medicine	□ Yes □ No	Hypoglycemia	□ Yes □ No	Venereal Disease	□ Yes □ No
COVID 19	□ Yes □ No	Kidney Problems	□ Yes □ No		□ Yes □ No

11. Do you have, or have you had any disease, condition, or problem not listed?.....□ Yes □ No
If YES, please list:_____

*OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.

***PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED**

*I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE EFFICIENT MANNER. I HAVE ANSWERED ALL THE QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK MY HEALTHCARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH OR MEDICATION.

Patient name: _____ Date: _____

Relationship to patient: _____ Signature: _____

Patient Confidentiality

Patient confidentiality is a prime concern in this office. Please indicate below with whom our office can or cannot leave a message.

Please check one where appropriate:

	YES	NO	DOESN'T APPLY
Spouse	☐	☐	☐
Children	☐	☐	☐
Answering Machine	☐	☐	☐
Email	☐	☐	☐
If yes, email address:			
Fax	☐	☐	☐
If yes, fax number:			

Are you able to receive calls at your workplace?.....☐ Yes ☐ No

May we call you at your workplace and state who is calling?.....☐ Yes ☐ No

Due to HIPPA confidentiality regulations, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you – the patient.

Please check with whom we may discuss your situation:

	YES	NO	DOESN'T APPLY
Spouse	☐	☐	☐
Children	☐	☐	☐
Answering Machine	☐	☐	☐
Email	☐	☐	☐
If yes, email address:			
Fax	☐	☐	☐
If yes, fax number:			

Children and/or Significant Other Information:

Name _____ | Name _____

Relationship _____ | Relationship _____

Phone _____ | Phone _____

Please Sign: _____ Date: _____

Erringer Family Dental Group Notice of Privacy Practices (HIPAA)

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.

I. Our Privacy Pledge and Duties

While we have and always will respect your privacy, a new federal law now requires us to maintain the privacy of dental health information and other medical information (including examination, treatment and billing records) about you and to provide you with this Notice of our legal duties and privacy practices with respect to such health information.

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change terms of our privacy notices. If we change the terms of the Notice, we will notify you during your next visit or by mail.

II. Permissible Uses and Disclosures Without Authorization

In certain situations (described in Section III below), we must obtain your written authorization in order to use and/or disclose your health information. However, here are some examples of how we might use or disclose your health information (other than highly confidential information) without first obtaining your written authorization:

A. Uses and Disclosures for Treatment, Payment or Health Care Operations

1. Treatment

   Your dental health care professional or staff member may use and disclose your health information to diagnose, assess and treat your health condition.

2. Payment

   Our insurance and billing staff may disclose your health information to an insurance carrier, HMO, PPO, your employer, or other party that arranges or pays the cost of some or all of your health care, or to verify that such parties will pay for your health care.

3. Health Care Operations

   Your dental health care professional and members of the staff may use or disclose your health information for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.

4. Appointment Reminders

   Your dental health care professional and members of the staff may need to use your name, address, phone number, and other health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine or at another location that you reasonably request.

5. Other Providers

   Your dental health care professional and members of the staff may use or disclose your health information to another health care provider, product manufacturer, or a hospital if it is necessary to refer you to them or they are otherwise involved in your care when such information is required for them to treat you, receive payment for

services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Disclosures to Relatives, Close Friends and Other Caregivers

Your dental health care professional and members of the staff may use or disclose your health information to one of your family members, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify your dental health care professional.

If you are not present, you are incapacitated or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. We may also disclose your health information to notify such persons of your location or general condition.

C. Other Permitted Uses and Disclosures Without Your Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your authorization in these following circumstances:

1. Public Health Activities

   We may disclose your health information for certain public health activities such as (i) reporting health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (ii) reporting child abuse and neglect to authorities authorized by law to receive such reports; (iii) reporting information about products or services under the jurisdiction of the U.S. Food & Drug Administration; (iv) alerting a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition; and (v) reporting information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

2. Victim of Abuse, Neglect or Domestic Violence

   If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose health information to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence.

3. Health Oversight Activities

   We may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health care programs such as Medicare or Medicaid.

4. Judicial and Administrative Proceedings

   We may disclose your health information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

5. Law Enforcement Officials

   We may disclose your health information to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

6. Decedents
   We may disclose your health information to a coroner or medical examiner as authorized by law.
7. Organ and Tissue Procurement
   We may disclose your health information to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.
8. Research
   We may use or disclose your health information if an Institutional Review Board approves a waiver of authorization for use or disclosure.
9. Health or Safety
   We may use or disclose your health information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.
10. Specialized Government Functions
    We may use or disclose your health information to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.
11. Workers' Compensation
    We may disclose your health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.
12. As Required by Law
    We may use or disclose your health information when required to do so by any other law not already referred to in the preceding categories.

III. Uses and Disclosures Requiring Your Authorization

A. Uses or Disclosure with Your Authorization

Other than the circumstances described above, any other use or disclosure of your health information will only be made with your written authorization. Additionally, you have the right to refuse to give us authorization to use or disclose your health information for purposes other than those described above. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

B. Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have taken an action in reliance upon such authorization before we receive your request to revoke your authorization.
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at the address given in Section VII below.

C. Marketing

We must also obtain your written authorization prior to using your health information to make you aware of products or services that you may have an interest in purchasing from time to time. We can, however, provide you with marketing materials in a face-to-face encounter without obtaining your authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without first obtaining your authorization. Additionally, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings.

D. Uses and Disclosures of Your Highly Confidential Information

In addition, federal and state law requires special privacy protections for certain highly confidential information about you. In order for us to disclose your highly confidential information for a purpose other than permitted by law, we must obtain your written authorization.

E. Right to Refuse Authorization

You have the right to refuse to give us an authorization to use or disclose your health information or otherwise contact you for purposes other than those set forth in Section II above. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

IV. Your Individual Rights

A. Your Right to Receive Confidential Communication Regarding Your Health Information.

We normally provide information about your health in person, at the time you receive dental care services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide by an alternative means of communication or at an alternative location. To help us respond to your needs, please make any requests in writing.

B. Right to Request Additional Restrictions

You may request restrictions on our use and disclosure of your health information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your general location and general condition. All requests for such restrictions must be made in writing. While we consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.

C. Your Right to Inspect and Copy Your Health Information

You may request access to your health information maintained by us in order to inspect and/or copy your health information. We require your request to inspect an/or copy your

health information to be in writing. If you request copies, we will charge you **$20.00**. We will also charge you for our postage costs, if you request that we mail the copies to you.

D. Your Right to Amend Your Health Information

You have the right to request that we amend your health information maintained by us. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

E. Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request, provided such request does not apply to disclosures that occurred prior to April 14, 2003. The accounting will include all disclosures except those disclosures:

- Required to carry out treatment, payment and health care operations to you.
- That are incident to a permitted use or disclosure.
- Made pursuant to an authorization.
- Required to maintain a directory of the individuals in our facility or to individuals involved with your care.
- Required for national security or intelligence purposes.
- To correctional institutions or law enforcement officers.
- Made as part of a limited data set.
- Made prior to April 14, 2003.

If you request an accounting more than once during a twelve (12) month period, we will charge **$0.25** per page of the accounting statement.

V. Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal law.

VI. Your Right to Obtain Further Information; Complaints

If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about providing you access to your health information, please contact us. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, we will provide you with the address for the Director. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint or request information at any time, written comments should be addressed to:

Erringer Family Dental Group
1755 Erringer Road, Suite 21
Simi Valley, CA, 93065

VII. Your Right to Receive a Paper Copy of this Notice

Upon written request, you may obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically.

VIII. Effective Date

This Notice is effective as of April 14, 2003.