



PATIENT NAME _____ SSN _____
BIRTHDATE _____ MALE/FEMALE (CIRCLE APPROPRIATE SEX)
ADDRESS _____
TELEPHONE: HOME _____ BUSINESS _____
CELL _____ OTHER _____
OCCUPATION _____ EMPLOYER _____
SPOUSE NAME _____ TELEPHONE _____
PERSON TO CONTACT IN EMERGENCY _____
RELATIONSHIP TO PATIENT _____ TELEPHONE _____
PERSON RESPONSIBLE FOR ACCOUNT _____ SSN _____
REFERRED BY _____

INSURANCE INFORMATION

IF YOU HAVE DENTAL INSURANCE, AND YOU WISH US TO FILE YOUR INSURANCE COMPANY FOR PAYMENT OF SERVICES RENDERED, YOU WILL NEED TO COMPLETE THE FOLLOWING INFORMATION. PLEASE NOTE THAT DENTAL INSURANCE IS NOT DESIGNED TO COVER ALL FEES.

NAME OF DENTAL INSURANCE COMPANY _____
NAME OF EMPLOYEE'S COMPANY _____
EMPLOYEE NAME _____ EMPLOYEE SSN _____
EMPLOYEE DATE OF BIRTH _____ POLICY NUMBER _____
GROUP NUMBER _____

AUTHORIZATION, RELEASE AND AGREEMENT FOR SERVICES RENDERED

I AUTHORIZE DR. SEEKAND AND HER STAFF TO RELEASE ANY INFORMATION, INCLUDING DIAGNOSIS, AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME AND/OR MY FAMILY DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR OTHER HEALTH PRACTITIONERS.

I AUTHORIZE AND HEREBY REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO DR. SEEKAND INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL FEES FOR SERVICES.

I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDENTS.

I UNDERSTAND THIS RECORD WILL BE IN EFFECT FOR ONE (1) YEAR OR UNTIL I GIVE WRITTEN NOTIFICATION TO CHANGE THE ABOVE.

SIGNATURE OF PATIENT (OR GUARDIAN IF MINOR) DATE _____

Health History Form



E-mail:	Today's Date:
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As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____ <small>Last First Middle</small>	Home Phone: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()
Address: _____ <small>Mailing address</small>	City:	State: Zip:
Occupation:	Height:	Weight: Date of birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: Cell Phone: () () <small>Include area codes</small>
If you are completing this form for another person, what is your relationship to that person?		
Your Name	Relationship	
Do you have any of the following diseases or problems: <i>(Check DK if you Don't Know the answer to the question)</i>		
Active Tuberculosis.....		Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.		

Dental Information For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____	Phone: <i>Include area code</i> ()			If yes, what was the illness or problem?			
Address/City/State/Zip: _____				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p>(Check DK if you Don't Know the answer to the question)</p> <p>Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date Treatment began: _____</p> <p>Allergies - Are you allergic to or have you had a reaction to: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Number of weeks: _____ Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Metals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Latex (rubber) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Hay fever/seasonal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Animals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Food <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p>Artificial (prosthetic) heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Congenital heart disease (CHD) Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Systemic lupus erythematosus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>G.E. Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Hepatitis, jaundice or liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Fainting spells or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Neurological disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, specify: _____</p> <p>Sleep disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Mental health disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Specify: _____</p> <p>Recurrent Infections <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Type of infection: _____</p> <p>Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Persistent swollen glands in neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Severe headaches/ migraines <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Severe or rapid weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Excessive urination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

<p>Cardiovascular disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Damaged heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Other congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Rheumatic heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, date: _____</p> <p>Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Hepatitis, jaundice or liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Fainting spells or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Neurological disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, specify: _____</p> <p>Sleep disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Mental health disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Specify: _____</p> <p>Recurrent Infections <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Type of infection: _____</p> <p>Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Persistent swollen glands in neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Severe headaches/ migraines <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Severe or rapid weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Excessive urination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK

Name of physician or dentist making recommendation: _____ Phone: _____


Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No DK
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST





FINANCIAL POLICY

We strive to provide you and your family with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please feel free to ask if you have any questions about our fees, Financial Policy, or your financial responsibility.
.....

All patients must complete the patient information forms prior to being seen by the doctor, the hygienist, or the dental assistant.

Full payment is due at the time of service unless prior arrangements have been made in writing.

We accept Cash, Checks, VISA, American Express, Discover, and MasterCard for payments.

THERE WILL BE A \$25.00 CHARGE FOR ALL RETURNED CHECKS.

Since we operate on an appointment only basis, we do our best to schedule your appointments at a time of your choosing and even call to confirm your scheduled appointment time in advance. **It is important that you inform the office 48 hours in advance if you will not be able to keep your appointment.**

Occasionally we find people that are inconsiderate of their time commitments. *For those few, we reserve the discretion to charge them thirty dollars [\$30.00] for their broken and/or missed appointments.*

INSURANCE INFORMATION

Any co-payment and/or deductible required by your insurance company is due at the time of service.

If your insurance company has not paid the FULL BALANCE within thirty (30) days from the date of service, you will have fifteen (15) days to pay the balance in full to avoid any finance charges.

Late Payment Charges of 1.5% per month (18% per year) of the unpaid balance will be added to all accounts after forty-five (45) days from the date of service.

If your insurance company pays **MORE** than the estimated amount, we will issue you a credit to your account or a refund check.

If your insurance company pays **LESS** than our original estimate, we will send you a bill for the unpaid balance that is due.

Please be aware that your insurance company may not cover certain procedures. For example, if you elect to have tooth colored fillings instead of metal fillings placed on certain teeth, your insurance company may select to reimburse based upon the fees for a metal filling. ***The difference of these fees will be your responsibility.***
.....

By Signing below, I acknowledge that I have read and agree to the Financial Policy as stated above.

Responsible Party Signature: _____ **Date:** _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have been given the opportunity to receive a copy of this office's "Notice of Privacy Practices".

Please Print Name

_____ Date _____

Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our "Notice of Privacy Practices", but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please Specify).
