DATE: _____

GENERAL HEALTH INFORMATION

CHART #_____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

Reason for Visit / Main Concern? Check-Up ❑ Cleaning ❑ Toothache ❑ Other _____

DENTAL HISTORY

❍ When did you last visit a dentist? _____
❍ When were dental x-rays taken? _____
❍ When was your last dental cleaning? _____
❍ Have you had gum or periodontal therapy? _____
❍ Do your gums bleed easily? YES ❑ NO ❑
❍ Do you feel you have bad breath? YES ❑ NO ❑
❍ Do you have difficulty flossing? YES ❑ NO ❑
❍ Are your teeth sensitive to hot or cold? YES ❑ NO ❑
❍ Do you clench or grind your teeth (bruxism)? YES ❑ NO ❑
❍ Do you experience clicking, popping, pain or locking of your jaw (TMD/TMJ)? YES ❑ NO ❑
❍ Are you in pain or discomfort? YES ❑ NO ❑
If yes, describe the location of the pain or discomfort and when did this begin? _____
❍ Have you ever been previously dissatisfied with dental treatment? YES ❑ NO ❑
If yes, please describe: _____

SMILE SELF ASSESSMENT

❍ Are you happy with your smile? YES ❑ NO ❑
❍ Are you self conscious when smiling or showing your teeth? YES ❑ NO ❑
❍ Would you like whiter teeth? YES ❑ NO ❑
❍ Are your gums healthy looking? YES ❑ NO ❑
❍ Do you have chipped teeth, crooked teeth, or gaps in your smile? YES ❑ NO ❑
❍ Are you interested in improving your smile and overall oral health with Cosmetic Dentistry or Orthodontics? YES ❑ NO ❑

MEDICAL HISTORY

❍ Are you under a physician's care at this time? YES ❑ NO ❑ If yes, please specify _____ Dr. Name & #: _____
❍ Have you ever been concerned, diagnosed, or treated for snoring or sleep apnea? YES ❑ NO ❑ Explain: _____
❍ Are you allergic to latex, penicillin, codeine, local anesthetics, pine nuts or any other drug, medicine or substance? _____
❍ Are you taking any medications at this time, including birth control? YES ❑ NO ❑ If yes, please specify: _____
❍ (Women) Are you pregnant now? YES ❑ NO ❑ If yes, how many months? _____ Are you nursing? YES ❑ NO ❑
❍ Are there any other health problems of which we should be advised? Please specify: _____
❍ Name of previous Dentist? _____ ❍ Reason for leaving previous Dentist? _____
❍ Can we contact your previous Dentist to get a copy of your records and x-rays? YES ❑ NO ❑
❍ Do you have, or have you had, any of the following?

Please check "YES" or "NO"		Doctor Comments	Please check "YES" or "NO"		Doctor Comments
ARTIFICIAL HEART VALVE/ STENT/GRAFT	YES ❑ NO ❑		ORAL HERPETIC LESIONS	YES ❑ NO ❑	
			HEARING IMPAIRED	YES ❑ NO ❑	
HEART ATTACK/SURGERY	YES ❑ NO ❑		DIABETES TYPE____HbA1c_____	YES ❑ NO ❑	
HEART MURMUR/DEFECTS	YES ❑ NO ❑		LIVER DISEASE/JAUNDICE	YES ❑ NO ❑	
HEART TROUBLE/ANGINA	YES ❑ NO ❑		HEPATITIS TYPE_____	YES ❑ NO ❑	
HEART PACEMAKER	YES ❑ NO ❑		ASTHMA	YES ❑ NO ❑	
STROKE	YES ❑ NO ❑		EMPHESEMA	YES ❑ NO ❑	
HIGH/LOW BLOOD PRESSURE	YES ❑ NO ❑		DIZZY SPELLS/FAINTING	YES ❑ NO ❑	
BLEEDING DISORDERS	YES ❑ NO ❑		EPILEPSY/SIEZURES	YES ❑ NO ❑	
ANEMIA/PROLONGED BLEEDING	YES ❑ NO ❑		ARTHRITIS	YES ❑ NO ❑	
HIV/AIDS+	YES ❑ NO ❑		ANY JOINT REPLACEMENTS	YES ❑ NO ❑	
CANCER/LEUKEMIA	YES ❑ NO ❑		STEROID TREATMENT	YES ❑ NO ❑	
CHEMO/RAD THERAPY	YES ❑ NO ❑		BISPHOSPHONTE THERAPY	YES ❑ NO ❑	
ULCERS/GERD	YES ❑ NO ❑		OSTEOPOROSIS	YES ❑ NO ❑	
KIDNEY DISEASE/DIALYSIS	YES ❑ NO ❑		CHEMICAL DEPENDANCY	YES ❑ NO ❑	
TUBERCULOSIS/LUNG DISEASE	YES ❑ NO ❑		PSYCHIATRIC CARE	YES ❑ NO ❑	
SINUS TROUBLE	YES ❑ NO ❑		TOBACCO USE	YES ❑ NO ❑	
THYROID PROBLEMS	YES ❑ NO ❑		COSMETIC SURGERY	YES ❑ NO ❑	
GLAUCOMA	YES ❑ NO ❑		IMPLANT/TRANSPLANT	YES ❑ NO ❑	

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature _____ Date _____
(Parent if Patient is a Minor)

Doctor Signature _____

MEDICAL UPDATE:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____

PATIENT INFORMATION

CHART # _____

PATIENT

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____

Phone ( ) _____

Cell ( ) _____

E-mail _____

Social Security # _____

DL# _____

Age _____ Birthdate _____

Primary Language _____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____

Phone ( ) _____

Social Security # _____ DL# _____

Relationship to Patient _____

Age _____ Birthdate _____

EMPLOYMENT

Occupation _____

Employer _____

How Long? _____

Business Address _____

City _____ Zip _____

Business Phone ( ) _____ Ext. # _____

Verified By _____ Date _____
(Office use only)

PERSON TO CONTACT FOR EMERGENCY:

_____
Last First

Relationship _____ Phone ( ) _____

Primary Care Physician _____

Phone ( ) _____

INSURANCE / DENTAL PLAN

Primary: Insurance PPO HMO (Circle one)

Plan Name _____

Address _____

City, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE / DENTAL PLAN

Secondary: Insurance PPO HMO (Circle one)

Plan Name _____

Address _____

City, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE / MEDICAL PLAN

Primary: Insurance PPO HMO (Circle one)

Plan Name _____

Address _____

City, State, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.
5. By signing below, I authorize that you/your agents/third parties who are assisting on our behalf may send me an email and text message appointment reminders, marketing material, and account updates, including electronic billing statements.

_____ _____
Signature of Responsible Party or Patient (Parent if Patient is a Minor) Date

(COMPLETE BOTH SIDES)

BASIC INFORMED CONSENT FOR GENERAL DENTISTRY

Patient Name:_____ Chart #:_____ Office:_____ Birthdate: _____

All patients complete 1 thru 4 below and 5 thru 13 as needed.

1. EXAMINATIONS AND X-RAYS:
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan. Some of the treatment like taking x-rays, placement of the restorations, polishing, etc. may be performed by a trained assistant or a Restorative Functions dental assistant.

(Initials _____)

2. DRUGS, MEDICATION AND SEDATION:
I have been informed and understand that anesthetics, antibiotics, analgesics or other medications can have reactions including allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the dentist of any known allergies. They may cause drowsiness, 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, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). It is critical that I tell my dentist of all medications currently being taken, including OTC and supplements since all medications have the potential for accompanying risks, side effects, and drug interactions. The written informed consent, in the case of a minor, shall include, but not be limited to, the following information: Administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of clinician, the age and health of the patient and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your child's anesthesia for his or her dental treatment, and consult with your dentist or pediatrician as needed.

(Initials _____)

3. 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 being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

(Initials _____)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD):
I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, the cost of which is my responsibility and I may be referred to a specialist for treatment.

(Initials _____)

5. DENTAL PROPHYLAXIS (CLEANING)/GINGIVITIS:
I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease. I understand that the diagnosis of gingivitis (moderate to severe inflammation/bleeding) may require an alternate procedure for treatment. (Initials _____)

6. FILLINGS:
I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling and that adjustment/s may be necessary. (Initials _____)

This signature line applies to California only:

I, _____ acknowledge I have received from Dr. _____ a copy of the Dental Materials Fact Sheet dated October 2001. (Initials _____)

7. REMOVAL OF TEETH:
Alternatives, if any, to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are in pain, tooth breakage, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials _____)

8. CROWNS, BRIDGES, VENEERS AND BONDING:
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crown/s, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crown/s are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation as directed by the dentist. Excessive delays may allow for decay, tooth movement, tooth breakage, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials _____)

9. NITROUS OXIDE:
I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not recommended if I am pregnant.

(Initials _____)

10. DENTURES – COMPLETE OR PARTIAL:
I realize that full or partial dentures are artificial, removable and constructed of plastic, metal, and/or porcelain, which require regular adjustment/s and/or reline/s. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initials _____)

11. ENDODONTIC TREATMENT (ROOT CANAL):
I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canal treatments are more brittle than other teeth, they are more prone to breakage and require a crown to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

(Initials _____)

12. PERIODONTAL TREATMENT:
I understand that I have a serious condition causing gum inflammation, infection and/or bone loss, which can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

(Initials _____)

13. IMPLANTS:
I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices, and infections may occur post operatively which may necessitate further treatment and even removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be of a temporary or, rarely, permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating Dentist.

(Initials _____)

14. TOOTH WHITENING OR BLEACHING:
Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea, red wine and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The dentist may prescribe fluoride or other treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials _____)

15. DENTAL BENEFITS:
I understand that my insurance benefits may not provide for ideal or comprehensive dental care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the dentist's recommendation of optimal dental treatment.

(Initials _____)

Acknowledgment:

- I have received, discussed and understand my proposed treatment, alternate treatment plan options, and their associated risks with the dental team and have had all my questions fully answered.
- I understand that each dentist is an individual clinician and the only one responsible for the dental care rendered to me, and that no other dentist or corporate entity is responsible for my dental treatment.
- I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees or promises been made to me concerning the treatment, my recovery or any results from the treatment to be rendered to me. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.
- I understand that if any unexpected difficulties occur during treatment, I may be referred to another clinician or a specialist for further care at additional expense to me.

Patient/Parent/Guardian Signature: _____ Date: _____

Treating Dentist Signature: _____ Date: _____

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us in writing how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us in writing how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Ask us in writing how to do this.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the last page of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Contact Information

Business Support :: (714) 578-6487
Monday – Friday 8:00 a.m. to 5:00 p.m. Pacific Time

Effective Date – October 1, 2016

Chart # _____

Patient Acknowledgement of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me.

_____ _____
Patient's Signature Date

_____
Print Legal Guardian's Name (if patient is a minor)

_____
Legal Guardian's Signature

For office use only:

☐ Patient refused a copy of the Notice of Privacy Practices (NPPs).
☐ Patient refused to sign Acknowledgement of NPPs.

_____ _____
Print Name (office staff) Date

_____
Signature

Place the completed copy in the patient's chart.