

# Health History Form

**ADA** American Dental Association®

America's leading advocate for oral health

Email: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

## 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"/>
Is your mouth dry?..... <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"/>
Have you had any periodontal (gum) treatments?..... <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 ever had orthodontic (braces) treatment?..... <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 had any problems associated with previous dental 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"/>
Is your home water supply fluoridated?..... <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"/>
Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	What was done at that time?
Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:
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: Include area code ( )	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 dietary 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.

<small>(Check DK if you Don't Know the answer to the question)</small>		<b>Yes No DK</b>	
Do you wear contact lenses?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia®, Boniva®, Reclast®, Prolia®) for osteoporosis or Paget's disease?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Date Treatment began: _____			
<b>Allergies.</b> Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.		<b>Yes No DK</b>	
Local anesthetics.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Aspirin.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Penicillin or other antibiotics.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Barbiturates, sedatives, or sleeping pills.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Sulfa drugs.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Codeine or other narcotics.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</b>			
<b>Yes No DK</b>		<b>Yes No DK</b>	
Artificial (prosthetic) heart valve.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Previous infective endocarditis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Damaged valves in transplanted heart.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Repaired (completely) in last 6 months.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Repaired CHD with residual defects.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<small>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</small>			
<b>Yes No DK</b>		<b>Yes No DK</b>	
Cardiovascular disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Angina.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Arteriosclerosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Congestive heart failure.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Damaged heart valves.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Heart attack.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Heart murmur.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Low blood pressure.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
High blood pressure.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Other congenital heart defects.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Mitral valve prolapse.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Pacemaker.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Rheumatic fever.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Rheumatic heart disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Abnormal bleeding.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Anemia.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Blood transfusion.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
If yes, date: _____			
Hemophilia.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
AIDS or HIV infection.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Arthritis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Autoimmune disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Rheumatoid arthritis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Systemic lupus erythematosus.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Asthma.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Bronchitis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Emphysema.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Sinus trouble.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Cancer/Chemotherapy/ Radiation Treatment.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Chest pain upon exertion.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Chronic pain.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Diabetes Type I or II.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Eating disorder.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Malnutrition.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Gastrointestinal disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
G.E. Reflux/persistent heartburn.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Ulcers.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Thyroid problems.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Stroke.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Glaucoma.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Hepatitis, jaundice or liver disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Epilepsy.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Fainting spells or seizures.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Neurological disorders.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
If yes, specify: _____			
Sleep disorder.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Do you snore?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Mental health disorders.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Specify: _____			
Recurrent Infections.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Type of infection: _____			
Kidney problems.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Night sweats.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Osteoporosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Persistent swollen glands in neck.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Severe headaches/migraines.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Severe or rapid weight loss.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Sexually transmitted disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Excessive urination.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....			
Name of physician or dentist making recommendation: _____		Phone: Include area code (    ) _____	
Do you have any disease, condition, or problem not listed above that you think I should know about?.....			
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: _____
Signature of Dentist: _____	Date: _____

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

OKUDA FAMILY DENTAL LLC  
4970 WEST 190TH STREET  
TORRANCE, CALIFORNIA 90503  
(310) 370-1272

PATIENT REGISTRATION

DATE\_\_\_\_\_

NAME\_\_\_\_\_

ADDRESS\_\_\_\_\_

CITY\_\_\_\_\_STATE\_\_\_\_\_ZIP CODE\_\_\_\_\_

ACCOUNT TYPE: JOINT ☐ FAMILY ☐ OR INDIVIDUAL ☐

SINGLE/MARRIED\_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT (HUSBAND/WIFE/GUARDIAN IF JOINT OR FAMILY ACCOUNT)

NAME\_\_\_\_\_

ADDRESS\_\_\_\_\_TELEPHONE\_\_\_\_\_

CITY\_\_\_\_\_STATE\_\_\_\_\_ZIP CODE\_\_\_\_\_

EMPLOYER\_\_\_\_\_OCCUPATION\_\_\_\_\_

ADDRESS\_\_\_\_\_TELEPHONE\_\_\_\_\_

CITY\_\_\_\_\_STATE\_\_\_\_\_ZIP CODE\_\_\_\_\_

SOCIAL SECURITY NUMBER\_\_\_\_\_DATE OF BIRTH\_\_\_\_\_

INSURANCE COMPANY\_\_\_\_\_

POLICY OR GROUP NUMBER\_\_\_\_\_

OTHER DENTAL INSURANCE COVERAGE\_\_\_\_\_

POLICY OR GROU P NUMBER\_\_\_\_\_

POLICY HOLDER\_\_\_\_\_

SOCIAL SECURITY NUMBER\_\_\_\_\_DATE OF BIRTH\_\_\_\_\_

ACKNOWLEDGEMENT AND AUTHORITY

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT FIRST NAMED ABOVE, INCLUDING BUT NOT RESTRICTED TO WHATEVER DRUGS, MEDICINE, PERFORMANCE, OR OPERATIONS AND CONDUCT OF LABORATORY, X-RAYS, OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING DOCTOR, OR HIS ASSISTANT OR QUALIFIED DESIGNATE.

I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAYFOR THEM, IN FULL, AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN WRITING.

SIGNED\_\_\_\_\_

(PATIENT OR RESPONSIBLE PARTY-MUST BE 18 YEARS OR OLDER)

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## OKUDA FAMILY DENTAL LLC

# NOTICE OF PRIVACY PRACTICES

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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

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

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 make the new Notice available upon request.

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.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician 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.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. 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.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, 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.

**To Your Family and Friends:** 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 a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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 incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common 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.

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

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security authorities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

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## **PATIENT 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 information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.25 for each page, \$15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate 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 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location and provide satisfactory explanation 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.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## **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.

Contact Officers: Toshiyuki Jerry Okuda, D.D.S. and Kenneth Okuda, D.D.S.

Telephone: 310-370-1272

Fax: 310-370-0124

E-mail: [office@okudadds.com](mailto:office@okudadds.com)

Address: 4970 West 190<sup>m</sup> Street, Torrance, California 90503

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OKUDA FAMILY DENTAL LLC

**ACKNOWLEDGEMENT OF  
RECEIPT OF NOTICE OF PRIVACY  
PRACTICES**

"You May Refuse to Sign This Acknowledgement"

I, \_\_\_\_\_ have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 2002).