**WELCOME TO OUR PRACTICE!**

Patient information

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: F / M Age: \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single\_\_\_\_\_ Married\_\_\_\_\_ Divorced\_\_\_\_\_ Widowed\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party/ Name of Insured:

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single\_\_\_\_\_ Married\_\_\_\_\_ Divorced\_\_\_\_\_ Widowed\_\_\_\_\_

Primary Insurance Company:

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number/Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company:

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number/Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Method of Payment: Cash \_\_\_\_\_ Visa/MC\_\_\_\_\_ Check \_\_\_\_\_

**How did you hear about our practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Medical History Information:

***Full disclosure of the following information is relevant to your well-being. The information you provide is confidential and necessary to avoid any serious drug interactions or death. Please answer these questions honestly so we may provide the best care possible.***

**Do you have any allergies or have you had any reactions to the following?**

**Penicillin** Y / N **Aspirin** Y / N **Iodine** Y / N **Codeine** Y / N **Sulfa Drugs** Y / N **Barbiturates** Y / N

**Erythromycin** Y / N **Latex** Y / N **Dental Anesthesia** Y / N **Lidocaine** Y / N

**Y / N Do you have any food allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any other drugs allergies or reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Y / N- Have you ever been seriously ill?

Y / N- Have there been any changes in your general health recently?

Y / N- Are you currently being treated by a medical doctor? If so, Name of Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y / N- Have you ever been hospitalized? When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y / N- Have you ever had a major operation?

Y / N- Have you had a physical exam in the last year?

Y / N- Have you ever had to take antibiotics before having dental work?

Y / N- Do you have artificial joints or heart valves?

Y / N- Do you have chest pains upon exertion?

Y / N- Have you ever had radiation treatment or chemotherapy for a tumor, growth or any other condition?

Y / N- Have you been exposed to the AIDS virus (HIV)?

Y / N- Are you currently using any recreational drugs such as Cocaine or controlled substances?

Y / N- Do you Smoke/Chew/Snuff Tobacco products?

Y / N- Do you consume alcohol? How often? Rarely\_\_\_\_\_\_\_\_ Sometimes \_\_\_\_\_\_\_\_\_ Often \_\_\_\_\_\_\_\_\_

Y / N- Have you ever had a blood transfusion?

Y / N- Have you ever experienced an unusual reaction to dental anesthetic?

Y / N- Do you bleed for a long time when you cut yourself?

Y / N AIDS/HIV

Y / N Anemia

Y / N Arthritis

Y / N Asthma

Y / N Canker sores/cold sores

Y / N Dental Anxiety

Y / N Diabetes

Y / N Epilepsy

Y / N Hay Fever

Y / N Headaches

Y / N Hearing aids/problems

Y / N Heart Attack

Y / N Heart Murmur

Y / N Hepatitis

Y / N Herpes

Y / N High Blood Pressure

Y / N Hives/Skin Rashes

Y / N Jaundice

Y / N Kidney Disease

Y / N Mental problems

Y / N Mitral Valve Prolapse

Y / N Rheumatic Fever

Y / N Seizures

Y / N Stroke

Y / N Tuberculosis

Y / N Venereal Disease

**Please list medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WOMEN ONLY

Y / N Are you pregnant?

Y / N Are you taking oral contraceptives (birth control pills)?

Y/ N Do you have clearance from your physician to have dental work during pregnancy?

Women who are taking antibiotics should take precautions since antibiotics may cause birth control pills to fail and could result in pregnancy.

Dental History Information:

When was your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_ When was your last cleaning? \_\_\_\_\_\_\_\_\_\_\_\_

What was done then? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y / N Did you have X-rays?

Name of Previous Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y / N Do you have 6month cleaning history?

Y / N Do you have fluoride in your drinking water or do you take a fluoride supplement?

Y / N Have you ever had periodontal (gum) treatments?

Y / N Do you have any inflammation in your gums?

Moderate\_\_\_\_\_\_\_\_ Severe\_\_\_\_\_\_\_\_ Condition of Saliva\_\_\_\_\_\_\_

Y / N Have you had braces?

How often do you floss? \_\_\_\_\_\_\_\_\_

What kind of toothbrush do you use?

Hard Medium Soft

What is the general condition of your teeth? GOOD\_\_\_\_\_ FAIR \_\_\_\_\_\_ POOR\_\_\_\_\_\_

What is the general condition of your gums? GOOD\_\_\_\_\_ FAIR \_\_\_\_\_\_ POOR\_\_\_\_\_\_

Y / N Do your gums bleed? When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y / N Does food collect between your teeth?

Y / N Do you have bad breath?

Y / N Do you have any gum recession?

Y / N Have you lost many teeth? Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y / N Were there any complications with extractions?

Y / N Have any of your teeth been replaced by:

 (Circle which one) A fixed bridge A removable partial A denture

Y / N Do you eat sweets?

Y / N Do you eat raw vegetables?

Y / N Do you eat between meals?

Y / N Are your teeth sensitive to heat?

Y / N Are your teeth sensitive to cold?

Y / N Are your teeth sensitive to sweets?

Y / N Is there any pain in the region of the ear?

Y / N Do you have difficulty hearing?

How do you feel about your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Any concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Agreement Policy:

RELEASE:

1. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

2. I authorize release of any information concerning my (or my child’s) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

3. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full on all of my accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor. This also gives Dr. Christine P. Gatti the right to file insurance and that benefits will be assigned to the aforenamed dentist.

I attest to the accuracy of this information.

Insurance and Billing:

We will gladly assist you in filing your insurance for most dental procedures. Please understand that your insurance is a contract between you, your employer and your insurance company. We will be an advocate for you but we cannot be responsible for settling any disputed claims or coverage. Please remember you are ultimately responsible for your bill owed to us. We do have financing options.

We accept payment at time of service.

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge.

Signature of Patient or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DR. CHRISTINE P. GATTI, DMD

908 N Sandhills Blvd Us Hwy 1

Aberdeen, NC 28315

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 of Patient or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Office Use Only

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

\_\_\_\_ Individual refused to sign

\_\_\_\_ Communications barriers prohibited obtaining the acknowledgment

\_\_\_\_ An emergency situation prevented us from obtaining acknowledgment

Other (please specify)

@ 2002 American Dental Association

All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This form is educational only, does not constitute legal advice, and covers only federal, not state law (August 14, 2002).

DR. CHRISTINE P. GATTI, DMD

908 N Sandhills Blvd Us Hwy 1

Aberdeen, NC 28315

NOTICE OF PRIVACY PRACTICES

NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND

DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION IS IMPORTANT TO US.

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 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_, 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, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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 your 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 of 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 directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences to your best interest in allowing 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 activities. 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).

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 contact 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 $­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_ for each page, $\_\_\_\_\_\_\_\_\_ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. 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 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.

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 Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

@ 2002 American Dental Association

All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This form is educational only, does not constitute legal advice, and covers only federal, not state law (August 14, 2002).