Carolina Pediatric Dentistry

North Raleigh / Wake Forest
2800 Wakefield Pines Drive, Suite 110
Raleigh, NC 27615

Downtown Raleigh
510 Glenwood Avenue, Suite 110
Raleigh, NC 27605

T (919) 570-0180
F (919) 570-0280
www.CarolinaPedo.com

E. LaRee Johnson, DDS, MS, FAAPD
Diplomate, American Board of Pediatric Dentistry
Clark L. Morris, DDS
Diplomate, American Board of Pediatric Dentistry
Trang T. Nguyen, DDS, MS
Diplomate, American Board of Pediatric Dentistry
Miranda R. Kalaskey, DDS
Pediatric Dentist

v2022.05.26

NEW PATIENT INTAKE FORM

Thank you for ensuring a legal guardian for the child completes this form thoroughly. By doing so, you are assisting us in providing the most friendly, safe, and efficient care for your child!

How did you hear about us? Check all that apply and list your referral or friend's name so we can thank them!
☐ Google Search ☐ Facebook ☐ Instagram ☐ Referring doctor ☐ Family/Friend: _____ ☐ Other: _____

CHILD'S DEMOGRAPHIC INFORMATION

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____
Preferred Name: _____ Birthday: _____ Age: _____ Sex: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Phone for Appt Reminders: _____ Name of School/Daycare: _____ Grade: _____
Child Lives with: _____ Siblings' Names & Ages: _____

Please provide the following information if the patient is under 18 years of age or has a legal guardian:

Parent/Guardian #1: _____ DOB: _____ Email: _____
Mobile Phone: _____ Home: _____ Work: _____ Employer: _____
Relationship to Child: _____ SSN: _____ Legal Custody of Child ☐Y ☐N
Same address as child? ☐ Yes ☐ No, my address is: _____
☐ I authorize patient photos to be sent to me by email at the address listed above

Parent/Guardian #2: _____ DOB: _____ Email: _____
Mobile Phone: _____ Home: _____ Work: _____ Employer: _____
Relationship to Child: _____ SSN: _____ Legal Custody of Child ☐Y ☐N
Same address as child? ☐ Yes ☐ No, my address is: _____
☐ I authorize patient photos to be sent to me by email at the address listed above

Emergency Contact: _____ Phone: _____ Relationship to Child: _____

Person Responsible for Payments on Account: _____
If different from parent/guardian above:
Relationship to Child: _____ DOB: _____ SSN: _____
Mobile Phone: _____ Home: _____ Work:_____ Employer: _____

Reason for your child's dental visit: _____
Additional comments or questions you may have: _____

Sometimes we make conversation by talking about upcoming holidays, cartoon characters, tooth fairy, etc. Is this OK with you? ☐ Yes ☐ No

What is a favorite something we can talk to your child about to make him/her comfortable? _____

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CHILD'S DENTAL HISTORY

Patient Name: _____

Is this your child's 1st dental visit? ☐ Yes ☐ No → Who saw your child? When? How did it go? _____

_____

Has your child had dental x-rays in the past six months? ☐ No ☐ Yes
Do you have concerns about your child's dental health? ☐ No ☐ Yes → Please describe: _____

_____

Is your child currently experiencing any dental problems? ☐ No ☐ Yes: _____

Do you give consent for fluoride at your child's first visit with us? ☐ Yes ☐ No
Do you give consent for dental radiographs if needed at your child's first visit with us? ☐ Yes ☐ No

How often are your child's teeth brushed? _____
Does your child use fluoridated toothpaste? ☐ No ☐ Yes
Does an adult assist your child with brushing? ☐ No ☐ Yes → How often? _____
Does an adult assist your child with flossing? ☐ No ☐ Yes → How often? _____
Do your child's gums bleed when brushed? ☐ No ☐ Yes
Does your child drink city water? ☐ No ☐ Yes
Was your child breastfed? ☐ No ☐ Yes → If stopped, at what age? _____

Which of the following drinks and food does your child consume *daily*? Check all that apply:
☐ Gatorade/Sports drinks ☐ Juice ☐ Soda/energy drinks ☐ Bottled water ☐ Tap water ☐ Milk ☐ Flavored milk ☐ Sparkling water
☐ Dried fruit/raisins ☐ Cereal or granola bars ☐ Gummies/vitamin gummies ☐ Fruit snacks/fruit roll-ups ☐ Cookies/crackers

Has your child experienced any of the following? If the habit has stopped, please specify at what age: _____
☐ Pacifier use ☐ Finger sucking ☐ Thumb sucking ☐ Nail biting ☐ Other: _____

Has your child ever worn an orthodontic appliance? ☐ No ☐ Yes
Does your child experience clicking or popping in the jaw (TMJ/TMD)? ☐ No ☐ Yes
Does your child wear a mouthguard for sports? ☐ No ☐ Yes
Does your child get cold sores or fever blisters? ☐ No ☐ Yes *Please explain:*
Does anyone in the family get cold sores or fever blisters? ☐ No ☐ Yes → _____
Does anyone in the family have missing teeth? ☐ No ☐ Yes → _____
Has your child inherited any dental conditions that you know of? ☐ No ☐ Yes → _____
Has your child had a dental injury (bumped/chipped tooth, bruised lip, etc.)? ☐ No ☐ Yes → _____

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CHILD'S HEALTH HISTORY

Patient Name: _____

Is your child under the care of a medical doctor at this time? ☐ No ☐ Yes → Last Medical Exam: _____
Name of Pediatrician/Clinic: _____ Are your child's immunizations current? ☐ Yes ☐ No
Has your child ever been hospitalized? ☐ No ☐ Yes →
Has your child received general anesthesia? ☐ No ☐ Yes →
Has your child had any excessive bleeding requiring special treatment? ☐ No ☐ Yes →
Has your child ever been diagnosed with a heart condition or heart murmur? ☐ No ☐ Yes →

If you answered yes to any of the four previous questions, please describe the reason or procedure and any complications: _____

Do you or your child use tobacco products? ☐ No ☐ Yes
Is your child adopted? ☐ No ☐ Yes → At what age? _____
Was the pregnancy and delivery without complications? ☐ Yes ☐ No → Please explain: _____

Does your child have any **allergies**? Check all that apply:

☐ Food allergy ☐ Ibuprofen/Motrin ☐ Lanolin ☐ Penicillin ☐ Rubber/Latex ☐ Seasonal ☐ Silver ☐ Sulfa ☐ Wool ☐ Other: _____

Please list any **medications** your child is currently taking, including vitamins/supplements or holistic remedies:

_____

Has your child taken any medications or drugs in the past two years? ☐ No ☐ Yes → _____

Does your child have any medical conditions? Check all that apply:

☐ ADD/ADHD	☐ Eating disorder	☐ Kidney disease	☐ Stomach problems
☐ Anemia	☐ Eczema/psoriasis	☐ Liver disease	☐ Stomach ulcers
☐ Anxiety	☐ Head injury	☐ Low blood pressure	☐ Substance abuse
☐ Autism spectrum disorder	☐ Hearing impairment	☐ Mouth breathing	☐ Thyroid problems
☐ Bleeding disorder	☐ Heart condition	☐ Nervous disorder	☐ Tumors
☐ Blood disease	☐ Heart disease	☐ Nutrition deficiency	☐ Vision impairment
☐ Bronchitis	☐ Heart murmur	☐ Psychiatric disorder	☐ Pregnant: Due date? _____
☐ Cerebral Palsy	☐ Hemophilia	☐ Respiratory problems	☐ Cancer: Type? _____
☐ Cleft lip/palate	☐ High blood pressure	☐ Sickle cell anemia	☐ Chemotherapy: When? _____
☐ Cystic fibrosis	☐ Intellectual disability	☐ Sinus trouble	☐ Radiation: When? _____
☐ Diabetes	☐ Irregular heartbeat	☐ Snoring	☐ Stroke: When? _____
☐ Dizzy spells or fainting	☐ Jaundice	☐ Spina Bifida	☐ Other: _____

☐ Epilepsy or seizures: Last seizure? _____ Frequency? _____ Medication? _____
☐ Asthma: Last attack? _____ Frequency of inhaler use? _____ Rescue inhaler with you? _____

I understand that providing inaccurate information can be dangerous to my child's health. I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and that to the best of my ability, and that any questions that I had have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Print Name of Legal Guardian: _____ Relationship to Child: _____

Signature: _____ Date: _____

Pediatric Dentist's Signature: _____ Date: _____

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PATIENT ADVISORY AND ACKNOWLEDGEMENT:

Receiving Dental Treatment During the COVID-19 Pandemic

Patient Name: _____ DOB: _____

You have visited Carolina Pediatric Dentistry for dental services during the COVID-19 pandemic. Please be advised of the following: Our office follows infection control recommendations made by the American Dental Association (ADA), the U.S. Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA). We are considered an essential service and follow strict guidance from the North Carolina State Dental Board of Dental Examiners. Our team attests, to the best of their knowledge, they have not been exposed to COVID-19. All uniforms are laundered on-site, and shoes stay within the premises. We are minimizing the number of persons and interactions between persons at any one time in for best practices in risk mitigation. We are asking all who enter to wash hands upon entry/exit and all individuals over the age of two (2) to wear a mask. Since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

Please answer these screening questions to ensure the health and safety of your child, the children, and families we serve, as well as our team at Carolina Pediatric Dentistry:

1. Unwell with ANY of the following symptoms: fever >100.4°F in the last 24-48 hours, dry cough, sore throat, difficulty breathing, runny nose, nausea/vomiting, diarrhea, loss of smell/taste, unexplained rash, or headaches?
   a. **You (legal guardian)?** ☐ No ☐ Yes
   b. **Your child?** ☐ No ☐ Yes

2. Been in close contact* with an individual with 1) confirmed Coronavirus COVID-19 infection, 2) symptoms consistent with COVID-19, OR 3) anyone pursuing a COVID-19 test?
   a. **You (legal guardian)?** ☐ No ☐ Yes
   b. **Your child?** ☐ No ☐ Yes

*Close contact defined as being coughed/sneezed on, or interacting within 6 feet of a symptomatic or COVID-19 positive person without a face covering for >10 minutes

I understand Carolina Pediatric Dentistry's efforts are intended to minimize spread of COVID-19. I understand my child and my own risk of exposure to the coronavirus cannot be eliminated when we leave the safety of our home. **I pledge to contact Carolina Pediatric Dentistry if my child or I develop symptoms consistent with COVID-19 or are confirmed positive to COVID-19 <u>within the 48 hours following our visit</u>.**

_____ _____
Parent/Guardian **Date**

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OFFICE FINANCIAL/SCHEDULING POLICY FOR MEDICAID ELIGIBLE PATIENTS

Patient Name: _____ **Date of Birth:** _____

Please note the financial guidelines for Drs. Johnson, Morris, Nguyen, and Kalaskey' pediatric dental office.

We do not contact your insurance company to verify coverage. You are responsible for the full balance on your account. The parent/guardian bringing the child to his/her visits is responsible for payment on the account. Please see our insurance specialist or office manager with any questions.

You will need to present your insurance card at your first dental visit and at every subsequent visit. You will be required to pay in full if you do not have your insurance card at the time of visit.

We accept cash, Visa, MasterCard, Discover, Care Credit and personal check. If your personal check is returned for non-sufficient funds, you will be charged a $25 service fee.

I have read and understand this insurance policy. I also hereby authorize my insurance company to send payments directly to Johnson & Morris PLLC and understand that I am responsible for all remaining balances. If I have no dental insurance coverage, I understand that I am responsible for payment in full at each visit.

_____ _____ _____
Signature Date Driver's License #/State

Please note the scheduling guidelines for Drs. Johnson, Morris, Nguyen, Kalaskey' pediatric dental office.

We request that you cancel or reschedule any appointment **at least 24 hours prior to your appointment**. As a courtesy, we generally call to confirm all appointments and send reminder postcards for recalls, but this is not a guarantee. If your child misses an appointment or you fail to reschedule or cancel at least 24 hours prior to your appointment, you will receive a letter as a reminder. If your child misses a third appointment, your child will be dismissed from our office.

_____ _____
Parent Signature Date

_____ _____
Witness Date

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REQUEST AND CONSENT FOR DENTAL TREATMENT

A legal guardian must complete this form. Please read this form carefully. If you do not understand something to your satisfaction, please ask us for clarification.

1. I request and authorize dental treatment for my child by Dr. Johnson, Dr. Morris, Dr. Nguyen, Dr. Kalaskey and team.

   Patient name: _____ **Date of Birth**: _____

2. I am the legal guardian of the child named above. _____(**Initials**)

3. **I understand** that I will have sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment by Dr. Johnson, Dr. Morris, Dr. Nguyen, Dr. Kalaskey and team.

   3a. I further request and authorize the taking of dental x-rays, the use of topical and local anesthetic, the use of fluoride, and the use of nitrous oxide/oxygen as may be considered necessary to treat my child's dental need(s).

   3b. **I understand** that all my questions will be answered to my satisfaction, and I consent to the treatment and procedures prescribed for the patient on the treatment plan. **I understand** that I may revoke this consent to treatment at any time, and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

4. It is unusual but is possible for any of the following risks or complications to occur, including not limited to: the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

5. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives at Carolina Pediatric Dentistry.

6. **I understand** it is the goal of this dental office to accomplish dental treatment by the use of warmth, friendliness, persuasion, humor, charm, gentleness and kindness and understanding. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

7. **I understand** that should my child become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and or doctor to hold a patient's hands, stabilize the head and/or control leg movements for their safety. I also understand the routine use of "tooth pillows" (mouth props) may be necessary to be sure a child does not accidentally close their teeth while an instrument is in their

mouth that could harm them. I also understand that mouth props are sometimes necessary if a child refuses to open his/her mouth. _____ (**Initials**)

7a. **I understand** that it is a common response for children to cry before or during dental treatment or directly afterward when they see their parent. **I understand** the only way I can guarantee my child will not cry or be unhappy during dental treatment is if I elect to have his/her treatment completed in the operating room under general anesthesia.

7b. **I further understand** that should my child become uncooperative during dental procedures with excessive body movements, the patient may need to be wrapped in a "hug blanket" called a Pediwrap to prevent injury and enable Dr. Johnson, Dr. Morris, Dr. Nguyen, and/or Dr. Kalaskey safely provide the necessary treatment. *I will be consulted prior to the use of the Pediwrap.*

8. In accordance with the Federal Privacy Law, **I understand** that personal electronic devices are prohibited in patient care areas. **I understand** that CPD team members may use a designated clinic camera to take patient HIPAA-compliant photos for me at my request.

9. For the purpose of advancing medical-dental education, **I give permission** for the use of clinical photographs, video and/or radiographs of the patient for diagnostic, scientific, educational, certification or research purposes.

10. **I authorize** the taking of photographs of my child with a designated clinic camera for marketing and advertising purposes (i.e. website, Facebook, Instagram, print materials, etc.): □ Yes □ No

11. **I give permission** for my child to watch **any Disney animated movie rated G or PG:** □ Yes □ No

12. **Family Behavior Policy: I understand** CPD has a "no tolerance" policy for the following: abusive conduct, profanity/cussing, crude graphics, threatening, or aggressive behavior, and/or larceny. This applies to patients, other family members/visitors, CPD team and pediatric dentists. There are no further warnings, second chances or exceptions for a violation. A violation will result in immediate transfer of care to a new dental home of my choice. I am committed to keeping this a wholesome, family-friendly environment for impressionable young children.

13. **Immunization Policy: I understand** that CPD requires up-to-date immunizations for every team member, pediatric dentist, and patient of record unless documentation from a medical provider is submitted detailing medical reasons otherwise. I understand leaving the safety of my home increases my child's risk and my own risk of contracting transmissible diseases for which there are no vaccines.

14. **I confirm** that I am a legal guardian to the child referenced on the opposite page. **I also confirm** that I have read this form or it was read to me, and I understand this form. **I also confirm** that all blanks were filled in and any paragraph that does not apply was stricken before I signed below.

Signature of Person Consenting to Treatment/Relationship to child	Date
Signature of Doctor	Date
Witness Certification	Date

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I have read and understand Carolina Pediatric Dentistry's Notice of Privacy Practices. Specifically, I understand that my protected health information will be used to:

- Conduct, plan and direct my (or my child's) treatment and follow-up among other healthcare providers who may be involved in that treatment
- Obtain payment (e.g. insurance companies, collection agencies, check processing companies)
- Conduct normal healthcare operations such as quality assessment

I also understand that the usual business practice of this office is to use an open bay for most treatment and to call or text to confirm appointments prior to most appointments. Please check the appropriate boxes below if you want something other than our usual business practice:

- ☐ Do not use an open bay for patient treatment. Schedule all appointments for the VIP room. I understand that this may limit my ability to schedule appointments as there is only one private treatment room in this office.
- ☐ Do not call to confirm appointments. I understand that missing appointments may result in dismissal from the office.
- ☐ Do not text to confirm appointments. I understand that missing appointments may result in dismissal from the office.
- ☐ Do not email to confirm appointments. I understand that missing appointments may result in dismissal from the office.

Patient Name: _____

Caregiver Name: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____ Date of Birth: _____

Entity to receive information. Indicate each person/entity that you approve to receive information.	**Description of information to be released.** Check each box below if **person/entity on the left** can receive that type of information
☐ Email _____ ☐ Cell Phone _____ ☐ Voice Mail _____	☐ Pre-Med ☐ Other _____
Name(s) of Parents: _____	☐ Financial ☐ Medical
Name(s) of Grandparent/Relative/Other Caregiver: _____ _____	☐ Financial ☐ Medical ☐ Can Sign for Treatment
When coordinating treatment with fellow providers, please check the box to the right to authorize emailing x-rays.	☐ Check here for email authorization (this is secured email). I understand while extremely rare, it is possible for email to be viewed by others.
Name of Pediatrician/Primary Care Physician so we may send a follow up letter regarding patient's dental visit: _____	☐ Check here for fax and email authorization (this is secured email). I understand while extremely rare, it is possible for email to be viewed by others.

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attach necessary documentation)

---------- **OFFICE USE ONLY** ----------

I attempted to obtain the patient's (or parent's) signature in acknowledgement of this Notice of Privacy Practices, but I was unable to do so as documented.

☐ Patient or parent was given notice but forgot sign before leaving the office.
☐ Patient or parent refused to sign.
☐ Notice was mailed to patient or parent.

Team Member Signature and Date:
_____