Welcome to
JACKSON FAMILY DENTISTRY
PATIENT REGISTRATION

Name _____ *(Circle one)* Mr. Mrs. Ms. Miss Dr.
Last First Mi

Preferred Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

E-Mail _____ **Date** _____

May we contact you at this e-mail address? YES NO

		May we contact you at this number?		May we leave a message for you at this number?	
Home Phone		YES	NO	YES	NO
Cell Phone		YES	NO	YES	NO
Work Phone		YES	NO	YES	NO

Date of Birth _____ **Gender** *(circle one)* Male Female

Social Security Number _____ *(Circle one)* Single Married Divorced Widowed Separated

If married, the name of your spouse _____

Employer _____ **Occupation** _____

Emergency contact _____
Name Phone # Relationship to patient

Who may we thank for referring you to our office? _____

Primary Insurance

Do you have dental insurance coverage? YES NO

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's/Subscriber's Name _____

Insured's/Subscriber's Date of Birth _____ **Relationship to patient** _____

Insured's/Subscriber's ID or SS# _____

Insured's/Subscriber's Employer _____

Secondary Insurance

Do you have secondary dental insurance coverage? YES NO

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's/Subscriber's Name _____

Insured's/Subscriber's Date of Birth _____ **Relationship to patient** _____

Insured's/Subscriber's ID or SS# _____

Insured's/Subscriber's Employer _____

(PLEASE CONTINUE ON THE OTHER SIDE)

Name of Previous Dentist _____

Previous Dentist Address _____

Previous Dentist Phone Number _____

Consent

1. I authorize the doctor and/or designated staff to take x-rays, study models, photograph and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Patient/Parent/Guardian Signature _____ **Date** _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient/Parent/Guardian Signature _____ **Date** _____

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved.)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment, co-insurance, and deductibles that my insurance does not cover. I hereby authorize payment directly to Jackson Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Patient/Parent/Guardian Signature _____ **Date** _____

We accept Visa, Master Card, Discover, cash and/or check.

Our office is HIPAA Compliant and is committed to meeting and exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

JACKSON FAMILY DENTISTRY
MEDICAL HISTORY

Name: _____ **Date:** _____

Your current physical health is: **Good** **Fair** **Poor**

Do you use tobacco (smoking, snuff, chew, bidis)? **Yes** **No**

If so, how interested are you in stopping? (*circle one*) VERY SOMEWHAT NOT INTERESTED

Do you drink alcoholic beverages? **Yes** **No**

If yes, how much alcohol do you consume per week _____

Do you use controlled substances (drugs not prescribed to you or illegal)? **Yes** **No**

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger, shoulder) replacement? **Yes** **No**

Date: _____ If yes, do you have to be pre-medicated? **Yes** **No**

Have you ever taken or plan on taking Fosamax®, Actonel®, or any other bisphosphonate? **Yes** **No**

Have you ever taken the drug Phen-Fen or Redux? **Yes** **No**

Medications: Are you currently taking or have you recently taken any prescription or over the counter medicine(s)? **Yes** **No**

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

For Women:	Yes	No	
Are you using a prescribed method of birth control?			
Are you pregnant or think you may be pregnant?			Number of weeks _____
Are you nursing?			

Are you allergic to any of the following? ***Please mark (x) your responses***

	Yes	No		Yes	No	
Animals			Iodine			Please list any other drugs/materials
Antibiotics **(Please detail to right)**			Latex (rubber)			that you are allergic to:
Aspirin			Local Anesthetics			
Barbiturates or sedatives			Metals			
Codeine or other narcotics			Sulfa Drugs			
Food						

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

Do you have any of the following? ***Please mark (x) your responses***	Yes	No
Artificial prosthetic heart valve		
Previous infective endocarditis		
Damaged heart valves		
Congenital heart defect		
Mitral Valve Prolapse		
Artial fibrillation		

	Yes	No		Yes	No	
Abnormal Bleeding			Bronchitis			Excessive urination
Alcohol/Drug Abuse			Cancer/Chemotherapy			Fainting Spells
Alzheimer's Disease			Celiac Disease			Fever Blisters/Cold Sores
Anemia			Chest Pain (Angina Pectoris)			Fibromyalgia
Arthritis			Chronic Cough			Frequent Headaches
Artificial Bones/Joints			Colitis			GERD
Artificial Valves			Diabetes Type I			Glaucoma
Asthma			Diabetes Type II			Gout
Autoimmune disease			Difficulty Breathing			Hay Fever
Blood Disorders			Emphysema			Heart Attack
Blood Transfusion			Epilepsy			Heart Murmur
						Heart Surgery
						Hemophilia
						Hepatitis A
						Hepatitis B
						Hepatitis C
						High Blood Pressure
						HIV+/AIDS

(PLEASE CONTINUE ON THE OTHER SIDE)

Do you have any of the following? ***Please mark (x) your responses*** *(CONTINUED FROM PREVIOUS PAGE)*

	Yes	No		Yes	No		Yes	No
Hypoglycemia			Parathyroid Disease			Stroke		
Kidney Dialysis			Psychiatric Problems			Swollen Ankles/Feet/Hands		
Kidney Problems			Rheumatic Fever/Scarlet Fever			Thyroid Problems		
Liver Problems			Radiation Treatment			Tuberculosis (TB)		
Low Blood Pressure			Recurrent Infections			Tumor or Growths		
Lung Problems			Seizures			Ulcers		
Lupus			Sexual Transmitted Disease			Yellow Jaundice		
Nervous Disorder			Shingles					
Neurological Disorder			Sickle Cell Disease/Traits					
Night Sweats			Sinus Trouble					
Organ Transplant			Sjogrens					
Osteoporosis/Paget's Disease			Sleep Disorder					
Pacemaker			Stomach/Intestinal Disease					

Are you now under the care of a physician? **Yes** **No** ***(if yes, please complete next two sections)***

Physician Name: _____ Phone: *Include area code* (_____)_____

Address/City/State/Zip Code:

Has there been any change in your general health within the past year? **Yes** **No**
If yes, please explain:

Date of last physical exam:

Have you had a serious illness, operation or been hospitalized in the past five (5) years? **Yes** **No**
If yes, please explain:

Have you ever had a serious accident involving head injuries? **Yes** **No**
If yes, please explain:

Have you lost or gained more than ten (10) pounds in the last year? **Yes** **No**

Do you have any other physical conditions, disease, or problem not listed on this Medical History? **Yes** **No**
If yes, please explain:

I understand the information provided in this Medical History is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. **I will notify the doctor (dentist) of any change in my health or medications.**

Patient/Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

JACKSON FAMILY DENTISTRY

DENTAL HISTORY

WELCOME! So that we may provide you with the best possible care, please complete this dental history form. Thank you!

Name _____ Date _____

What is the reason for your dental visit today?_____

Have you been satisfied with your previous dental care? ☐ YES ☐ NO

If no, please explain _____

Date of last dental visit: _____ Last dental cleaning: _____

How often do you brush your teeth? _____ How often do you floss? _____

Type of bristles? (*circle one*) Soft Medium Hard

What other dental aids do you use? (Rubber tip, waterpick, Electric Toothbrush) _____

Do you have any dental problems? (Please describe) _____

Your current dental health is (*circle one*) Good Fair Poor

1	Do you require antibiotics before dental treatment?	☐ YES	☐ NO	
2	Would you like to keep all of your teeth all of your life?	☐ YES	☐ NO	
3	Are any of your teeth sensitive to hot, cold, sweets, biting, or chewing?	☐ YES	☐ NO	
4	Do you frequently get cold sores, blisters, or any other oral lesions?	☐ YES	☐ NO	
5	Have you noticed any mouth odors or bad tastes?	☐ YES	☐ NO	
6	Do your gums bleed or hurt?	☐ YES	☐ NO	
7	Have your parents experienced gum disease or tooth loss?	☐ YES	☐ NO	
8	Have you noticed any loose teeth or change in your bite?	☐ YES	☐ NO	
9	Does food tend to become caught between your teeth?	☐ YES	☐ NO	
10	Do you clench or grind your teeth while awake or asleep?	☐ YES	☐ NO	
11	Do you hold foreign objects with your teeth? (pencils, pens, nails, finger nails)	☐ YES	☐ NO	
12	Do you have tired jaws, especially in the morning?	☐ YES	☐ NO	
13	Do you have any noticeable wear on your teeth?	☐ YES	☐ NO	
14	Do you mouth breathe while awake or asleep?	☐ YES	☐ NO	
15	Do you snore?	☐ YES	☐ NO	
16	Have you ever had a problem or injury with your jaw joints?	☐ YES	☐ NO	
17	Does your bite feel uncomfortable or unusual?	☐ YES	☐ NO	
18	Do you have any tenderness in either jaw joint or jaw muscles when you open wide, chew or talk?	☐ YES	☐ NO	
19	Do you have frequent headaches?	☐ YES	☐ NO	
	If yes, please explain _____			
20	Do you ever have difficulty opening or closing your mouth?	☐ YES	☐ NO	
21	Have you ever had a bite plate or mouth guard?	☐ YES	☐ NO	
22	Have you ever had your teeth ground or the bite adjusted?	☐ YES	☐ NO	
23	Have you ever had orthodontic treatment? (braces)	☐ YES	☐ NO	
24	Have you ever had periodontal (gum) treatment?	☐ YES	☐ NO	
25	Have you ever had oral surgery (extractions)?	☐ YES	☐ NO	
26	Are you satisfied with the appearance of your teeth?	☐ YES	☐ NO	

27 If you could change your smile or mouth, what would you most like to change?

_____

_____

_____

(PLEASE CONTINUE ON THE OTHER SIDE)

29 Do you feel nervous about having dental treatment? ☐ YES ☐ NO

If yes, what is your biggest concern?_____

30 Have you ever had an upsetting dental experience? ☐ YES ☐ NO

If yes, please describe_____

31 Is there anything else about having dental treatment that you would like us to know? ☐ YES ☐ NO

If yes, please describe_____

Note: Both doctors and patients are encouraged to discuss any and all relevant health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form and the Medical History are 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 on the Dental and Medical History forms 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 have made in the completion of the Dental and Medical History forms.

Patient/Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

JACKSON FAMILY DENTISTRY

PERSONAL REPRESENTATIVE DISCLOSURE AGREEMENT

Instructions

Please fill out this form to appoint a personal representative to act on your behalf in discussing your dental health information and benefit coverage with Jackson Family Dentistry.

Your privacy is important to us. Please take a moment to provide the requested information about yourself and the person(s) you are designating to act on your behalf concerning your dental health. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly and speak to your personal representative.

I,(Patient Name)_____, do hereby grant permission for Jackson Family Dentistry to disclose my personal health information to the following personal representative(s): (spouse, sibling, parent, child, friend, etc.).

	Representative's Name	Relationship to Patient	Contact Number
1			
2			
3			
4			
5			
6			

Information to be disclosed (please check all that apply):

- ☐ Appointment dates and times
- ☐ Treatment plans and referrals
- ☐ Financial and billing information
- ☐ Any other pertinent dental health information related to treatment at this office
- ☐ None of the above

I understand that this permission will remain in effect unless a written cancellation has been provided to Jackson Family Dentistry's Privacy Official.

_____ _____

Patient Signature (or Parent Signature if patient is a minor) Date

_____

Patient's Date of Birth

_____ _____

Witness Signature Date

JACKSON FAMILY DENTISTRY

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.

Our Legal Duty

We are required by law to maintain the privacy of protected health information, provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or 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 may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records, may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury, or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 an inmate or patient's protected health information.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine HIPAA compliance.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt-out of receiving the communications.

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

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying and postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied an access request, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of your health information disclosures, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Officer: Tammie MacMullen, Manager
Telephone: (630) 963-6750 Fax: (630) 963-6761
E-mail: Mail@JacksonFamilyDentistry.us or Tammie@JacksonFamilyDentistry.us
Address: 2033 Ogden Avenue, Downers Grove, Illinois 60515

Last Updated: 12/22/2020

JACKSON FAMILY DENTISTRY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA'), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal health care operations, such as quality assessment and physician certifications.

I have received, read, and understood your Notice of Privacy Practices containing a more complete description of my health information's uses and disclosures. I understand that this Oral Health Care Professionals, LLC dba Jackson Family Dentistry has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Oral Health Care Professionals, LLC dba Jackson Family Dentistry at any time at the following address to obtain a current copy of the *Notice of Privacy Practices.* Jackson Family Dentistry, 2033 Ogden Avenue, Downers Grove, Illinois 60515

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Oral Health Care Professionals, LLC is not required to agree to my requested restriction, but if Oral Health Care Professionals, LLC dba Jackson Family Dentistry does agree, then Oral Health Care Professionals, LLC dba Jackson Family Dentistry is bound to abide by such restrictions.

Patient Name (Print): _____

Relationship to Patient: _____

Signature: _____ Date: _____

E-Mailing Health Information

In providing the best treatment for our patients, it might be necessary for Oral Health Care Professionals, LLC dba Jackson Family Dentistry to email your health information to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them, which will cost you less and permit you to have quicker service access.

I understand that my health information might need to be emailed to other specialists and dentists. I give my permission for this service.

Patient Name (Print): _____

Relationship to Patient: _____

Signature: _____ Date: _____

Cancellation & Rescheduling Policy:

When you make your appointment, the time we set aside for you is your time only. **We see our patients individually and value your time, and dislike keeping you waiting. We ask that you also respect our time.** If you are unable to keep your appointment, please notify us at **LEAST TWO (2) BUSINESS DAYS** in advance. A nominal fee will be charged to your account if this notice is not given. The fee is $1.00/minute for the length of your appointment time. This is a standing policy in our practice, and this notice is to inform you of the policy.

If you are 15 minutes or more late for your given appointment, we will reschedule for another day when we will have adequate time to give you the proper care you deserve! Thank you for your understanding!

I understand that the office may charge me should I fail to keep or late cancel my appointment _____ (patient initials).

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the *Notice of Privacy Practices* but was unable to do so as documented below.

Date _____ Reason _____ Initials_____