CARING HANDS DENTAL CLINIC

**PATIENT IDENTIFICATION FORM**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone No: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of Residence:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee Phone No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Married ( Circle One )

Language Used: English Spanish Other\_\_\_\_\_\_\_\_ Male Female ( Circle One )

Ethnic Background: optional ( Circle One ) Hispanic, African American, American Indian, Asian, White

**If there is a legal guardian, please fill in the information below:**

Parent’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work No: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Guardian’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work No: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fill out this section completely, including telephone numbers**

Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Previous Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Pharmacy Used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Insurance**

(circle one) PrimeWest Blue Plus Medica VA MA South Country HealthPartners Ucare

ID# (PMI# or Medical ID#) \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

“I authorize the release of my medical information to my insurance carrier as necessary to process any claims. I authorize payment of medical benefits to Caring Hands Dental Clinic for services rendered.” I also authorize release of my dental and medical information to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Name (please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Other than routine visits, have you been under the care of a medical doctor during the past two years? Yes No If yes, for what? ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician's name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medication, drugs or pills now? Yes No If yes, please list name and dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Have you had a bad reaction to any of the following: Aspirin Codeine Nitrous Oxide Tetracycline Valium Clindamycin Novocain Anesthetic Ibuprofen Erythromycin Percodan Penicillin Sulfa Sleeping Pills Any others not listed? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Indicate which of the following you have had, or have at present. Circle Yes or no to each item.

Heart (surgery, disease, attach)…. Yes No Ulcers ……… Yes No Hepatitis A (infectious) B (serum)…. Yes No Chest Pain………………………………. Yes No Latex Sensitivity … Yes No Venereal Disease ………………. Yes No Congenital Heart Disease ……… Yes No Diabetes ……………. Yes No AIDS ………………………………… Yes No Heart Murmur ………………………. Yes No Thyroid Problems … Yes No HIV Positive ……………………… Yes No High Blood Pressure ……………… Yes No Glaucoma ……………..Yes No Cold Sores/Fever Blisters …. Yes No Mitral Valve Prolapse ……………. Yes No Contact Lenses ……... Yes No Blood Transfusion …………… Yes No Artificial Heart Valve ……………... Yes No Emphysema …………… Yes No Hemophilia …………………….. Yes No Heart Pacemaker …………………… Yes No Chronic Cough………… Yes No Sickle Cell Disease ………….. Yes No Rheumatic Fever ……………………. Yes No Tuberculosis …………… Yes No Bruise Easily ……………………. Yes No Arthritis/Rheumatism …………….. Yes No Asthma ………………….. Yes No Liver Disease …………………… Yes No Cortisone Medicine ………………… Yes No Hay Fever ………………. Yes No Yellow Jaundice ……………… Yes No Swollen Ankles ……………………….. Yes No Allergies or Hives …… Yes No Neurological Disorders ….. Yes No Stroke …………………………………….. Yes No Sinus Trouble …………. Yes No Epilepsy or Seizures ………. Yes No Diet (special/restricted) ………….. Yes No Radiation Therapy …. Yes No Fainting or Dizzy spells ….. Yes No Artificial Joints (hip, knee, etc.).. Yes No Chemotherapy ………. Yes No Nervous/Anxious …………. Yes No Kidney Trouble ………………………… Yes No Tumors …………………… Yes No Psychiatric/Psychological Care Yes No

1. Do you take blood thinner or aspirin daily? Yes No
2. Have you lost or gained more than 10 pounds in the past year? Yes No
3. Do you have or have you had any disease, condition, or problem not listed Yes No If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Women: Are you pregnant? Yes Months\_\_\_\_\_\_ No Nursing? Yes No Taking birth control pills Yes No
5. List allergies to medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. List allergies to food or other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoker: Yes No

Smokeless Tobacco: Yes No

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

DENTAL HISTORY

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Dental Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last X-rays \_\_\_\_\_\_\_\_\_\_\_\_\_

What was done at your last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why have you chosen our office for your dental care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous dentist’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ St \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you made regular dental visits? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Floss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other dental aids do you use? (Water pik, Interplak, Toothpick, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are any of your teeth sensitive to**: **Have you ever had**:

Hot or Cold? Yes No Orthodontic treatment? Yes No

Sweets? Yes No Oral Surgery? Yes No

Biting or Chewing? Yes No Periodontal treatment? Yes No

Have you noticed any mouth odors or bad tastes? Yes No Your teeth ground or the bit adjusted? Yes No

Do you frequently get cold sores, blisters or A bite plate or mouth guard? Yes No

any other lesions? Yes No A serious injury to the mouth or head? Yes No

If so, please describe, including cause \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do your gums bleed or hurt?** Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have your parents experienced gum disease or

tooth loss? Yes No **Have you experiences:**

Does food tend to become caught in between Clicking or popping of the jaw? Yes No

your teeth? Yes No Pain? (joint, ear, side of face) Yes No

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Have you lost any teeth or had teeth removed? Yes No Headaches, neckaches, or shoulder aches? Yes No

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sore muscles (neck, shoulders) Yes No

Have they been replaced? Yes No

How? Fixed bridge Partial Denture Implant Are you satisfied with your teeth’s appearance? Yes No

Are you happy with replacement? Yes No Would you like to keep all your teeth all of your life? Yes No

If no, why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clench or grind your teeth while awake or sleeping? Yes No

Bite your lips or cheeks regularly? Yes No Is there anything else about having dental treatment that

Hold foreign objects with your teeth you would like us to know? Yes No

(pencils, pipe, pins, nails, fingernails) Yes No If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mouth breath while awake or asleep? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have tired jaws, especially in the morning? Yes No

Smoke/Chew Tobacco? Yes No

APPOINTMENT POLICY

CARING HANDS DENTAL CLINIC

If for any reason you are unable to keep an appointment, **you must call at least 24 hours prior** to the appointment or it will be considered a failed appointment.

Anyone arriving more than 15 minutes late may have to attempt to reschedule, as your appointment may be given to someone waiting.

It is very important that the appointment you schedule with our clinic is kept and you come on time. With the huge demand we have for our services it is necessary to have a policy in place regarding scheduled appointments.

Failure to keep an appointment or to come late may result in future dental problems due to lack of treatment. As well as denying someone else of receiving care.

For people 16 and older, one failed appointment puts you at the back of the waiting list, 2 failed appointments for 16 and older requires you to find a different dental provider or possibly be required to pay for the cost of **empty chair time which currently runs $160.00 per hour**, should you desire to continue being seen here**. Uninsured patients** will be asked to go elsewhere on first failed appointment and/or pay for empty chair time.

For children 15 and younger, one failed appointment, we keep you on the current list, 2nd failed appointment, you go to the back of the list and three failed appointments we ask that you find a different dental provider or possibly be required to pay for the cost of **empty chair** **time which currently runs $160.00 per hour** should you desire to continue being seen here.

The Staff at Caring Hands look forward to providing your dental needs, but due to the tremendous demand, we must adhere to the above policies for the benefit of all involved. We also understand weather, family and sickness and will try to be as fair as possible, but repeated cancellations can jeopardize your use of our services.

In 2018 the Clinic lost $275,450.00 from failed appointments - creating empty chair time.

**Please sign below that you have read and understand our appointment policy.**

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

PRINT

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

SIGN and DATE



The Notice of Privacy Practices tells you how Caring Hands Dental Clinic may use or disclose information about you. Not all situations will be described. Caring Hands Dental Clinic will provide to you, upon request, a copy of our Privacy Practices to keep or you can examine the framed pages located in our waiting room. Caring Hands Dental Clinic is required to share this information with you regarding our Privacy Practices and the information we collect and keep about you. Please review it carefully.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

\*You may refuse to sign this acknowledgment\*

I, (patient or decision maker’s name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed or been given a copy of the Caring Hands Dental Clinic’s Notice of Privacy Practices. I have had the opportunity to ask questions about how my information may be used.

We ask that you, the patient, or your parent, guardian or substitute decision maker sign this form. You do not have to sign. We use this form, which is required by the Government, to show that you have received Notice of the Privacy Practice. The information on this form applies to all current and future contacts while you are here or after you leave. It applies to contacts which are in person, on the phone, via fax, email or by mail.

Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

Caring Hands Dental Clinic attempted to obtain written acknowledgement of Receipt of our Notice of Privacy Practices, but signature could not be obtained because;

\_\_\_\_\_ Patient or decision maker refused to sign

\_\_\_\_\_ Patient or decision maker unable to sign

Staff signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this information is needed in a different form, please ask us for assistance.