Notice of HIPPA A Privacy Policy

Patient/ Representative signature:

_____

_____Medical Physician's Name: _____ Phone #: _____Pharmacy #:_____Are you currently under a physician's care? ❑ Yes ❑ No If yes, describe _____Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No

If yes, please describe

_____

Do you take antibiotics prophylaxis before dental procedures? ❑ Yes❑ No

Add any partner or parent to whom you want to make any dental or financial diction.

SIGNATURE OF PATIENT (OR PARENT): _____

DATE:_____