ACKNOWLEDGEMENT AND RECEIPT OF VLAD V. SHUSTER'S PRACTICE POLICIES

_____ **INITIAL.** I HAVE COMPLETED THE **MEDICAL HISTORY** FORM AND HAVE ANSWERED THE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE.

_____**INITIAL.** I AUTHORIZE THE DOCTOR TO OBTAIN ANY NECESSARY MEDICAL HISTORY OR CLEARANCE FOR TREATMENT FROM MY PHYSICIAN(S) AND ANY NECESSESARY DENTAL HISTORY OR INSURANCE INFORMATION FROM MY DENTIST(S) OR DENTAL INSURANCE CARRIER.

_____ **INITIAL.** I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ADVISE THE DOCTOR'S OFFICE OF ANY CHANGES IN MY PERSONAL INFORMATION OR MEDICAL HISTORY.

_____ **INITIAL.** I HAVE RECEIVED AND REVIEWED THE DOCTOR'S **NOTICE OF PRIVACY PRACTICES.**

_____ **INITIAL.** I HAVE RECEIVED AND REVIEWED THE **DENTAL MATERIALS FACT SHEET.**

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement was not obtained because:

> Communication barriers prohibited us from obtaining the acknowledgement.
> Patient or Parent/Guardian refused to sign.
> An emergency situation prevented us from obtaining acknowledgement.
> Other: _____

_____

Patient's name

_____ _____

Patient's or Parent/Guardian's Signature **Date**