CareConnect School Clinic

PATIENT INFORMATION

Patient's Name: _____
Date of Birth: _____ Sex: ☐ Male ☐ Female SS#: _____
Home Address: _____
City, State, Zip Code: _____
Home Phone Number: _____ Email: _____

Race: __American Indian or Alaska Native __Asian __Native Hawaiian or Other Pacific Island __More Than One Race
__White __Black or African American __Other Pacific Islander __Unreported/Refused to Report
Ethnicity: __Hispanic or Latino __Non Hispanic or Latino __Refused to Report

Father's Name: _____
Birth date: _____
Occupation: _____
Employer: _____
Home Address: _____
Street: _____
City, ST, Zip Code: _____
SS#: _____ Work Ph: _____
E-Mail: _____ Cell Ph: _____

Mother's Name: _____
Birth date: _____
Occupation: _____
Employer: _____
Home Address: _____
Street: _____
City, ST, Zip Code: _____
SS#: _____ Work Ph: _____
E-Mail: _____ Cell Ph: _____

Emergency Contact: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

Insurance Company Primary:
Insured: _____ EPO/HMO/PRO
Insurance Name: _____
Insurance Address: _____
City, ST, Zip Code: _____
Policy #: _____ Group #: _____

Insurance Company Secondary:
Insured: _____ EPO/HMO/PRO
Insurance Name: _____
Insurance Address: _____
City, ST, Zip Code: _____
Policy #: _____ Group #: _____

Referred By: _____

Patient's brothers and/or sisters including birthdates:

AUTHORIZATION: I hereby authorize the provider to furnish information to insurance carrier's concerning this illness/accident, and I irrevocably assign to the doctor all payments for medical services rendered. I understand that I am ultimately responsible for all charges whether covered or not by insurance.

_____

Parent Signature Date

CareConnect School Clinic

Child's Name:_____ Birth date: _____ Today's Date: _____

Name of person completing this form: _____

Relationship to child: _____

Please answer the following questions so we will be better able to help you assess and take care of your child's health. All answers will be confidential. Thank you.

Mother's Name: _____ Birth date: _____ Living in home? ___Yes___No
Father's Name: _____ Birth date: _____ Living in home? ___Yes___No
Guardian's Name: _____ Birth date: _____ Living in home? ___Yes___No

Is you child adopted? ___Yes___No If yes, age at the time of adoption: _____

Has your child had an allergic reaction to any drugs? ____Yes ___No If yes, what is (s)he allergic to? _____

Does your child have any other allergies (food, dust, pollen, bee or insect stings, feathers, etc.)? _____

_____

Does you child have, or has (s)he had, any of the following?

Skin problems of long duration
- ☐ Eczema
- ☐ Hives
- ☐ Frequent fevers
- ☐ Eye problems/trouble seeing
- ☐ May ear infections
- ☐ Hearing problems
- ☐ Speech problems
- ☐ Many colds
- ☐ Many sore throats
- ☐ Frequent coughing
- ☐ Chicken Pox
- ☐ Bronchitis/Pneumonia
- ☐ Asthma
- ☐ Hay Fever
- ☐ Heart murmur
- ☐ Stomach aches/ constipation/diarrhea
- ☐ Kidney/bladder problems
- ☐ Hernia
- ☐ Hip/leg/foot abnormalities
- ☐ Convulsions
- ☐ Bed wetting/soiling underpants/bedclothes
- ☐ Behavior problems
- ☐ Temper tantrums
- ☐ School problems
- ☐ Sleeping problems
- ☐ Eating paint
- ☐ Anemia
- ☐ Sickle Cell Anemia
- ☐ Diabetes
- ☐ Serious injury
- ☐ Tuberculosis
- ☐ Yellow Jaundice

Are there any other problems you would like to discuss? _____

_____

What prescription and non-prescription medicines is your child currently taking regularly? (Be sure to include such medicines as vitamins, iron, etc.) _____

_____

Was the pregnancy with this child: ___normal ___difficult? _____

Was this child born: ___on time ___late ___early?

What was the child's birth weight? ___lbs. ___ozs.

What type of milk did the child have? ___Breast feeding ___regular formula ___soy formula ___other: _____

Did your child have any problems during the first months of life (colic, feeding problems, loose bowels, vomiting, jaundice, etc)? ___Yes ___No

When did your child:

	On Time	Delayed	Not Yet
Smile	☐	☐	☐
Transfer objects from one hand to the other	☐	☐	☐
Crawl	☐	☐	☐
Walk by himself/herself	☐	☐	☐
Talk (two words together)	☐	☐	☐
Feed himself/herself	☐	☐	☐
Become bowel trained	☐	☐	☐
Become bladder trained	☐	☐	☐

If your child is in school, how is (s)he doing? ☐ Well ☐ Average ☐ Poorly

If your child has been in the hospital for a medical or surgical reason, complete the following (use a separate sheet if you need more space)

Date	City and State	Hospital	Reason

Have any members of your child's family (mother, father, brothers, sisters, grandparents, aunts, uncles, etc.) had the following?

	Who?		Who?
Drug Addiction		Emotional/Nervous Illness	
Anemia		Heart Trouble	
Arthritis		Hearing Defect/Loss	
Asthma/Hay Fever		Kidney Disease	
Birth Defect		Mental Retardation	
Convulsions		Thyroid Disease	
Diabetes		Tuberculosis	
Sickle Cell Anemia			

Please answer the following questions about the health of your child's immediate family (use a separate sheet if you need more space):

	Living	Date of Birth	Dead	Age at Death	Current Health/Cause of Death
Mother	☐		☐		
Father	☐		☐		
Brothers & Sisters					
	☐		☐		
	☐		☐		
	☐		☐		

When your child rides in the car, does he/she ride in a car seat or wear a seat belt? ☐ Yes ☐ No

Are there any particular problems or stresses for your family right now; for example, marriage difficulties, problems with other children, job pressures, financial problems, or illness in the family?

Is there any additional information which you think should be in your child's medical record?

CareConnect Health

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____

Last First MI Maiden or Other Name

Date of Birth:____-____-____ SS#:____-____-____

Month Day Year

Address:_____City:_____State:_____Zip:_____

Day Phone:_____ Evening Phone:_____

1. Authorization

I hereby authorize _____ (Name of Healthcare Provider) to release information from my medical record as indicated below to:

Name:_____(Individual seeking the information)

Address:_____ City:_____ State:_____ Zip:_____

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____.

OR

b. □ all past, present, and future periods.

3. Extent of Authorization

□I authorize the release of my **complete health record** (including records relating to mental healthcare, sexually transmitted diseases, HIV or AIDS, treatment of alcohol or drug abuse, and any drug screening results).

□ Other (please Specify) _____

OR

□ I authorize the release of my complete health record with the exception of the following information:

- □ Mental Health (including psychotherapy notes)
- □ Sexually Transmitted Diseases (including HIV and AIDS)
- □ Substance Abuse (including alcohol/drug abuse treatment)
- □ Drug Screening Results
- □ Other (please specify): _____

4. I understand that this authorization will expire within 1 year after I have signed the form.
5. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative Printed name of patient or personal representative

_____ _____

Relationship to patient Date

CareConnect School Clinic
Consent Form

In order for your child to receive services at CareConnect School Clinic, this consent form must be completed and proper documentation of insurance obtained.

I/We the undersigned parent(s)/guardian(s) to _____, a minor, do hereby
Name of Child
Authorize CareConnect School Clinic as agent for the undersigned to consent to any examination, medical diagnoses or treatment which is deemed advisable and is to be rendered at the office.

I authorize the Clinic to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law. Medicaid and other insurers will be billed for services rendered. Charges for services rendered to students not insured will be based on a sliding fee scale.

I understand that my signing this consent allows the clinician and professional clinic staff of CareConnect School Clinic to provide comprehensive health services. I authorize periodic dental examinations for my child, which may include photographs, radiographs, and any other acceptable methods for the dental evaluation and management of my child's dental health. I also understand that I have the right to withdraw this consent at any time upon written notice to CareConnect Health.

I have read and understand the above information and give permission for my child's care as described. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at _____.

_____ _____
Name of Parent or Legal Guardian ***Name of Patient***
(PLEASE PRINT) ***(PLEASE PRINT)***

_____ _____
Signature of Parent/Legal Guardian ***Relationship to Patient***

_____
Date

HIPAA Notice of Privacy Practices
CareConnect Health

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our HIPAA Compliance Officer at, PO BOX 5610, Cordele, GA, 31015, 229-273-8881.

OUR OBLIGATIONS:

We are required by law to maintain the privacy of protected health information, give you this notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

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

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the

President, other authorized persons or foreign heads of state or to conduct special investigations

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to PO BOX 5610, Cordele, GA 31015. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to PO BOX 5610, Cordele, GA, 31015.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to PO BOX 5610, Cordele, GA 31015.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to PO BOX 5610, Cordele, GA, 31015. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to PO BOX 5610, Cordele, GA 31015. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.swghc.org. To obtain a paper copy of this notice, contact the medical office.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Risk Manager at PO Box 5610, Cordele, GA 31015. All complaints must be made in writing. You will not be penalized for filing a complaint.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

Patient Name _____ Date of Birth _____ Patient Signature _____

Due to the inability of our Management Information System to document information for a report (UDS) that is required to be submitted annually on patients' income status; we will appreciate you completing the information below. Please **circle** the salary range which applies to you.

No Income

$1- $20,000

$20,000- $40,000

$40,000- $60,000

$60,000- $80,000

$80,000- $100,000

$100,000 and above

In Household: _____

Patient Name: _____

Date: _____

CareConnect School Clinic
Photography Consent Form

Parents of _____ Students:

If your child participates in any events held by the school-based clinic this year, we would like your permission to use pictures taken during the event. These pictures will *only* be used for posting to our digital media outlets for promotional purposes in order to spread awareness of the advantages that our school-based clinics bring to the community. Thank you for your continued support.

☐ YES. I give my permission for photographs of my child to be used by CareConnect School Clinic.

☐ NO. I do *not* give my permission for photographs of my child to be used by CareConnect School Clinic.

Child's Name: _____

_____ _____

Signature of Parent/Guardian Date

CareConnect Health

Child's Full Name: _____ Age: _____ DOB: ___/___/___
First Middle Last

Address: _____ City: _____ State: ____ Zip: _____

Home Phone Number: (___) ___-____ Sex: ___(M) ___ (F) Weight: _____ lbs.

Parent/Guardian Name: _____ Phone #: _____ E-mail: _____

Name of Physician: _____ Address of Physician: _____ Phone: _____

Name of School: _____

DENTAL AND MEDICAL HISTORY:

1. Has the patient had any injuries to the face, mouth, or teeth? _____ Yes No
2. Has the patient had any unusual or unpleasant experiences in a dental or medical office? _____ Yes No
3. Please discuss any serious medical problems that the child has had: _____ Yes No
4. Is the child's water fluoridated? _____ Yes No
5. Is your child currently taking fluoride supplements? If yes, please list. _____
6. Is the child currently taking any medicine? (Prescription, OTC, Herbal) If yes, please list. _____
   _____
7. Is your child allergic to any types of medicines? If yes, please list. _____
8. Has your child had a history of: (Please circle Yes or No)
   *If yes to any of the asterisk conditions, please call prior to your appointment….premedication may be required.

Congenital Heart Defects*	Yes	No	Allergies (Latex, Food, etc.)	Yes	No
Mitral Valve Prolapse*	Yes	No	Artificial Joint*	Yes	No
Heart Murmur*	Yes	No	Stomach/Intestinal Disorders	Yes	No
Rheumatic Fever*	Yes	No	Tuberculosis/Lung Disease	Yes	No
High/Low Blood Pressure	Yes	No	Attention Deficit Disorder	Yes	No
Bleeding Disorders	Yes	No	Epilepsy/Seizures	Yes	No
Sickle Cell Anemia*	Yes	No	Diabetes	Yes	No
Liver Disease	Yes	No	Developmentally Delayed	Yes	No
Kidney Disease	Yes	No	Cancer*	Yes	No
Chronic Ear Infections	Yes	No	Hepatitis	Yes	No
Tonsillitis	Yes	No	Autism	Yes	No
Snoring	Yes	No	Speech Problems	Yes	No
Asthma	Yes	No	Any Operations	Yes	No
Hearing Impairment	Yes	No	Other	Yes	No

9. Does your child have any of the following habits? Finger Sucking Pacifier Clenching/Grinding Nail Biting Other
10. Did either of the child's parents have braces? Yes No _____
11. Is there a history of missing or an abnormal number of teeth in the family? If yes, list: _____
12. Child's interests, hobbies or pets: _____

CONSENT FOR TREATMENT:

I understand the information that I have given is correct to the best of my knowledge and will be held in strict confidence. I hereby give consent to the dentist and staff to perform the dental treatment necessary to correct any oral problems the above child may have. I have been given an opportunity to ask questions I might have and that all questions about the procedures have been answered in a satisfactory manner.

Parent/Guardian:

Signature: _____

Date: _____

Hygienist:

Signature: _____

Date: _____