

# Patient Registration

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
 Last First Initial MM-DD-YY  
 Date of Birth \_\_\_\_\_  Male  Female

If Child: Parent's Name \_\_\_\_\_

How do you wish to be addressed \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed  Minor

Residence: Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contacts (please check preferred method)  
 Home Phone \_\_\_\_\_  Cell Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  Ok to text cell phone?  
 email \_\_\_\_\_

Patient Employer \_\_\_\_\_  
 Present Position \_\_\_\_\_ How Long \_\_\_\_\_

Spouse / Parent Name \_\_\_\_\_  
 Spouse Employer \_\_\_\_\_  
 Present Position \_\_\_\_\_ How Long \_\_\_\_\_

Who is responsible for the account? \_\_\_\_\_  
 Driver's License # \_\_\_\_\_

Method of Payment  Insurance  Cash  Credit Card

Purpose of Visit \_\_\_\_\_

Other Family members in the practice \_\_\_\_\_

Whom may we thank for the referral \_\_\_\_\_

Patient /Parent SSN \_\_\_\_\_

Spouse/Parent SSN \_\_\_\_\_

Emergency Contact Name/Number \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Policy # \_\_\_\_\_

Group # \_\_\_\_\_

SSN \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Policy # \_\_\_\_\_

Group # \_\_\_\_\_

SSN \_\_\_\_\_

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or the payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor. I attest to the accuracy of the information on this page.

X PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

S. CHRISTIAN BAHM, D.D.S. • JEFF TOLLETT, D.D.S.  
 GENERAL AND COSMETIC DENTISTRY

## Patient Medical History

Patient's Name \_\_\_\_\_ Chart# \_\_\_\_\_ DOB \_\_\_\_\_

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

<p>1. Are you under medical treatment now? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized for any surgical operations or serious illness within the last 5 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____</p> <p>3. Are you taking any medication(s) including Non-prescription? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes PLEASE LIST on THE MEDICATION FORM</p> <p>4. Have you ever taken Phen-Fen/Redux? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use tobacco? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use controlled substances? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you wearing contact lenses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have or have had any of the following?</p> <table border="0"> <tr> <td style="width: 50%; vertical-align: top;"> <table border="0"> <tr><td>High Blood Pressure</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Heart Attack</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Rheumatic Fever</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Swollen Ankles</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Fainting / Seizures</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Asthma</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Low Blood 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Are you allergic to or have had any reactions to the following?</p> <table border="0"> <tr><td>Local Anesthetics (eq. Novocaine)</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Penicillin or any other antibiotic</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Sulfa Drugs</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Barbiturates</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Sedatives</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Iodine</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Aspirin</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Any metals (nickel, mercury etc)</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Other (please list) _____</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table> <p>10. Women Only</p> <table border="0"> <tr><td>a) Are you or could you be pregnant?</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>b) Are you nursing?</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>c) Are you taking oral contraceptives?</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table> <table border="0"> <tr> <td style="width: 50%; vertical-align: top;"> <table border="0"> <tr><td>Chest Pains</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Easily Winded</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Stroke</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Hay Fever / Allergies</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Tuberculosis</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Radiation Therapy</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Glaucoma</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Recent Weight Loss</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Liver Disease</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Heart Trouble</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Respiratory Problems</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Mitral Valve Prolapse</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Other _____</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table> </td> <td style="width: 50%; vertical-align: top;"> <table border="0"> <tr><td>Chest Pains</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Easily Winded</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Stroke</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Hay Fever / Allergies</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Tuberculosis</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Radiation Therapy</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Glaucoma</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Recent Weight Loss</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Liver Disease</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Heart Trouble</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Respiratory Problems</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Mitral Valve Prolapse</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Other _____</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table> </td> </tr> </table>	Local Anesthetics (eq. 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type="checkbox"/>	Yes	<input type="checkbox"/>	No	Radiation Therapy	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Glaucoma	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Recent Weight Loss	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Liver Disease	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Heart Trouble	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Respiratory Problems	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Mitral Valve Prolapse	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other _____	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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Convulsions</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Leukemia</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Diabetes Type ____</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Kidney Disease</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>AIDS / HIV Infection</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Thyroid Problem</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table>	High Blood Pressure	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Heart Attack	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Rheumatic Fever	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Swollen Ankles	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Fainting / Seizures	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Asthma	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Low Blood Pressure	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Epilepsy / Convulsions	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Leukemia	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Diabetes Type ____	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Kidney Disease	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	AIDS / HIV Infection	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Thyroid Problem	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<table border="0"> <tr><td>Heart Disease</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input 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a) Are you or could you be pregnant?	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																																																																																																																																																																																																																																																																																																																																																																																																
b) Are you nursing?	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																																																																																																																																																																																																																																																																																																																																																																																																
c) Are you taking oral contraceptives?	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																																																																																																																																																																																																																																																																																																																																																																																																
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Loss</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Liver Disease</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Heart Trouble</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Respiratory Problems</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Mitral Valve Prolapse</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Other _____</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table>	Chest Pains	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Easily Winded	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Stroke	.....	<input 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## Patient Dental History

Previous Dentist \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

<p>1. Do your gums bleed while brushing or flossing? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain to any of your teeth? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you had any head, neck or jaw injuries? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever experienced these in your jaw?</p> <table border="0"> <tr><td>Clicking</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Pain (joint, ear, side of face)</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Difficulty opening/closing</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Difficulty chewing</td><td>.....</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table>	Clicking	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Pain (joint, ear, side of face)	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Difficulty opening/closing	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Difficulty chewing	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<p>8. Do you have frequent headaches? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you bite your lips or cheeks frequently? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you had difficulty with extractions? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had prolonged bleeding? With extractions? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you had orthodontic treatment (braces)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you like your smile? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Clicking	.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																				
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## Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

**X** Patient (or guardian) Signature: \_\_\_\_\_ Date \_\_\_\_\_  
Dentist Signature: \_\_\_\_\_ Date \_\_\_\_\_

S. CHRISTIAN BAHM, D.D.S. • JEFF TOLLETT, D.D.S.  
GENERAL AND COSMETIC DENTISTRY



**Notice of Information Practices and Privacy Statement For  
Jeff Tollett DDS PA**

1011 Augusta Dr Ste 100, Houston, TX 77057

**How We Collect Information About You:** Jeff Tollett DDS PA (JTDP) and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

**What We Do Not Do With Your Information:** Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

**How We Do Use Your Information:** Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between JTDP and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

**Information We Do Not Collect:** We do use cookies on our website to collect date from our site visitors, however, we do not collect information about site visitors except for hit counters on the main index page and subpages ([www.houstonpersonaldentist.com](http://www.houstonpersonaldentist.com)) that simply record the number of visitors. We do use some affiliate programs that may or may not capture traffic date through our site. To avoid potential data capture that you visited a dental website simply, do not click on any of our outside affiliate links as these are outside our control.

**Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources:** Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of JTDP. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Revision Date: 09/12/2013

*HIPAAPracticesStatement09122013*

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GENERAL AND COSMETIC DENTISTRY

JEFF TOLLETT DDS PA  
1011 AUGUSTA DR, SUITE 1 00  
HOUSTON, TX 77057

OFFICE@DRJEFFTOLLETT.COM  
(713) 622-3240 P  
(713) 622-3280 F



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

..You May Refuse to Sign This Acknowledgement..

I, \_\_\_\_\_, have received a  
copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
*(Please Print Name)*

X \_\_\_\_\_  
*(Signature)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
For Office Use Only  
\_\_\_\_\_

*We attempted to obtain written acknowledgement of receipt of our  
Notice of Privacy Practices, but the acknowledgement could not be  
obtained because:*

*Individual refused to sign*

*Communications barriers prohibited obtaining the acknowledgement*

*Other (Specify)*

\_\_\_\_\_

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