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# NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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## **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$12.00 for the first ten pages, \$0.25 for each additional page thereafter, \$20.00 to duplicate each full mouth radiograph, or portion, \$20.00 to duplicate each dental cast, \$12.00 per hour for staff time to locate and prepare your health information and postage and packaging fees if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Arnold B Cullum, DDS**  
**1732 Blake Street**  
**Denver, CO 80202**  
**Phone 303-814-2200**  
**Fax 719-623-0305**

**Arnold B Cullum, DDS**  
**251 E Fountain Blvd Unit 100**  
**Colorado Springs, CO 80903**  
**Phone 719-591-2004**  
**Fax 719-623-0305**

# 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.

{Signature}

{Date}

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### For Office Use Only

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

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgement
  - Patient refused copy of Notice of Privacy Practices
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## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Phone Numbers \_\_\_\_\_ SSN \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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### SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Contact Person:**

**Arnold B Cullum, DDS**  
1732 Blake Street  
Denver, CO 80202  
Phone 303-814-2200  
Fax 719-623-0305

**Arnold B Cullum, DDS**  
251 E Fountain Blvd Unit 100  
Colorado Springs, CO 80903  
Phone 719-591-2004  
Fax 719-623-0305

**Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.**

**CONSENT**

I, (Print Name) \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

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

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: \_\_\_\_\_

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

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in the patient's chart.**

**REVOCAION OF CONSENT**

I, (Print Name) \_\_\_\_\_, revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

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

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: \_\_\_\_\_

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

Whom May We Thank, For Referring You to Our Office? \_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Are You? Minor Single Separated Divorced Widowed Married

Date Of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male/Female

Spouse's Name \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Pager # \_\_\_\_\_

Work Phone # \_\_\_\_\_ Ext. \_\_\_\_\_ Other #S \_\_\_\_\_

Home Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Occupation \_\_\_\_\_ Year's At This Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

**Guarantor's Information (Person Responsible for Account)**

Relation to Patient \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date Of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male/Female

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Pager # \_\_\_\_\_

Work Phone # \_\_\_\_\_ Ext. \_\_\_\_\_ Other #S \_\_\_\_\_

Home Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Occupation \_\_\_\_\_ Year's At This Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

**Dental Insurance**

Primary Carrier

Secondary Carrier

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

Phone Number \_\_\_\_\_

Group Number \_\_\_\_\_

Policy Number \_\_\_\_\_

Subscriber's Name / SSN \_\_\_\_\_

**In Case of Emergency Contact**

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Ext. \_\_\_\_\_

I Certify That To The Best Of My Knowledge The Above Information Is Complete And Accurate.  
I Promise To Notify This Office within Two Weeks of Any Changes to My Patient Information.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

DOB \_\_\_\_\_ PATIENT NAME \_\_\_\_\_

# MEDICAL HISTORY

In order to provide safe and effective dental treatment all of the following questions must be answered.

- |     |  |             |        |
|-----|--|-------------|--------|
| 1.  | Physician's Name _____   | Phone _____ |        |
|     | Address _____  | Fax _____   |        |
| 2.  | Are you under a physician's care? _____  |             | NO YES |
|     | If yes, what for? _____  |             |        |
| 3.  | When was your last complete physical? _____  |             |        |
| 4.  | Are you taking any medications or substances? _____                                |             | NO YES |
| 5.  | Do you routinely take health related substances? _____                             |             | NO YES |
| 6.  | Are you allergic to any medications or substances? _____                           |             | NO YES |
| 7.  | Do you have any problems with antibiotics, anesthetics or other medications? _____ |             | NO YES |
| 8.  | Do you have any allergies? _____   |             | NO YES |
| 9.  | Are you sensitive to any metals or latex? _____                                    |             | NO YES |
| 10. | Have you been treated for or told you have heart disease? _____                    |             | NO YES |
| 11. | Do you have a pacemaker or a heart implant? _____                                  |             | NO YES |
| 12. | Have you ever had rheumatic fever? _____   |             | NO YES |
| 13. | Do you have a heart murmur? _____  |             | NO YES |
| 14. | Do you have any artificial joints or prosthesis? _____                             |             | NO YES |
| 15. | Do you have high or low blood pressure? _____                                      |             | NO YES |
| 16. | Do you have arthritis, rheumatism or other inflammatory disorder? _____            |             | NO YES |
| 17. | Do you have anemia, leukemia or other blood disorder? _____                        |             | NO YES |
| 18. | Have you ever bleed excessively after being cut or injured? _____                  |             | NO YES |
| 19. | Do you have any stomach or digestive problems? _____                               |             | NO YES |
| 20. | Do you have any kidney problems? _____   |             | NO YES |
| 21. | Do you have any liver problems? _____  |             | NO YES |
| 22. | Do you have high or low blood sugar levels? _____                                  |             | NO YES |
| 23. | Are you diabetic? _____  |             | NO YES |
| 24. | Do you have asthma, emphysema or tuberculosis? _____                               |             | NO YES |
| 25. | Do you have epilepsy or seizure disorders? _____                                   |             | NO YES |
| 26. | Do you now or have you had a venereal disease? _____                               |             | NO YES |
| 27. | Have you tested positive for HIV? _____  |             | NO YES |
| 28. | Have you tested positive for hepatitis? _____                                      |             | NO YES |
| 29. | Have you had psychological or psychiatric treatment? _____                         |             | NO YES |
| 30. | Do you use tobacco products? _____   |             | NO YES |
|     | If yes, which type and how often. _____  |             |        |
| 31. | Do you consume alcoholic beverages? _____  |             | NO YES |
|     | If yes, how often? If no, why? _____   |             |        |
| 32. | Do you use illicit drugs? _____  |             | NO YES |
|     | If yes, which type and how often. _____  |             |        |
| 33. | Do you have any disease, condition or problem not discussed above? _____           |             | NO YES |
|     | If yes, please explain. _____  |             |        |
| 34. | Is there anything else we should know about your health? _____                     |             | NO YES |
|     | If yes, please explain. _____  |             |        |
| 35. | For women, are you pregnant or suspect you may be? _____                           |             | NO YES |
|     | If yes, what trimester or month are you in today? _____                            |             |        |
| 36. | Are you using birth control medications? _____                                     |             | NO YES |

I certify that to the best of my knowledge, the above information is complete and accurate.  
I promise to notify this office immediately if there is a change in my health history.

Patient or Guardians Signature \_\_\_\_\_

Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Date \_\_\_\_\_

In order to provide safe and effective dental treatment all of the following questions must be answered.

1. Previous dentist name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Fax \_\_\_\_\_
2. Reason for today's visit? \_\_\_\_\_
3. When was your last dental visit and what did you have done? \_\_\_\_\_
4. Date and type of last dental radiographs (X-rays)? \_\_\_\_\_
5. When were your teeth last cleaned? \_\_\_\_\_
6. Do you brush your teeth? \_\_\_\_\_ NO YES  
If yes, how often? \_\_\_\_\_  
If yes, bristle strength is: soft medium hard
7. Do you floss? \_\_\_\_\_ NO YES  
If yes, unwaxed waxed tape periodontal or superfloss
8. Do you use mouth rinse? \_\_\_\_\_ NO YES  
If yes, what type? \_\_\_\_\_
9. Have you had teeth removed (pulled)? \_\_\_\_\_ NO YES
10. Were these teeth replaced? \_\_\_\_\_ NO YES
11. Do you wear complete dentures, partial dentures or fixed crowns or bridges? NO YES  
If yes, how old are they? \_\_\_\_\_  
If yes, are you pleased with them? \_\_\_\_\_  
If no, are you aware of dental implant successes? \_\_\_\_\_
12. Have you had periodontal treatment? \_\_\_\_\_ NO YES  
If yes, by which dentist and when? \_\_\_\_\_
13. Have you had a root canal? \_\_\_\_\_ NO YES  
If yes, by which dentist and when? \_\_\_\_\_
14. Have you had orthodontic (braces) treatment? \_\_\_\_\_ NO YES  
If yes, by which dentist and when? \_\_\_\_\_
15. Do you have sensitive teeth? \_\_\_\_\_ NO YES  
If yes, which ones? \_\_\_\_\_  
If yes, circle all that apply, Hot Cold Pressure (chewing) Sweets.
16. Are any of your teeth shifting or loose? \_\_\_\_\_ NO YES
17. Do your gums bleed or hurt? \_\_\_\_\_ NO YES
18. Do you have an unpleasant taste in your mouth? \_\_\_\_\_ NO YES
19. Do you feel you have bad breath? \_\_\_\_\_ NO YES
20. Does food wedge between your teeth? \_\_\_\_\_ NO YES
21. Do you wake up tired in the morning? \_\_\_\_\_ NO YES
22. Does your bed partner feel you snore? \_\_\_\_\_ NO YES
23. Does your jaw pop or click? \_\_\_\_\_ NO YES
24. Do you have pain in your ears or jaw joint? \_\_\_\_\_ NO YES
25. Do you have pain in your jaw when opening wide or moving to right or left? NO YES
26. Are you aware of clenching or grinding your teeth? \_\_\_\_\_ NO YES
27. How do you feel about your teeth? \_\_\_\_\_
28. Are you unhappy with the way your teeth look? \_\_\_\_\_ NO YES
29. Do you have difficulty eating the foods you want? \_\_\_\_\_ NO YES
30. Have you had an unpleasant dental experience? \_\_\_\_\_ NO YES
31. Have you ever had complications or illness following dental treatment? NO YES
32. Is there anything else that we should know about your dental history? NO YES  
If yes, please explain. \_\_\_\_\_

I certify that to the best of my knowledge the above information is complete and accurate.  
I promise to notify this office as soon as possible if there is a change in my dental history.

Patient or Guardians Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_

Date \_\_\_\_\_

## FINANCIAL AGREEMENT

DOB \_\_\_\_\_ Patient Name \_\_\_\_\_

Thank you for choosing us as your dental health care provider. We are committed to providing you with the finest quality dental services, that are consistent with your wants and needs. In order to provide safe, effective and informed dental treatment, proper information must be provided to you and your consent must be obtained.

### Financial Responsibility Agreement (Guarantor Must Read And Sign)

1. You agree that your payment portion is due at the time services are rendered. We accept cash, check, credit card payments and the "health care credit line". Payment options are made available on an individual basis.
2. You agree to be responsible for payment of all services rendered on your behalf or the person you are guarantor for.
3. As a courtesy to our patients we will process your insurance forms. Insurance coverage whether under a major medical or dental policy is a contract between the patient (and patient's employer) and the insurance company. It is **not** an agreement between our office and your insurance company. Our offices have an agreement with you, the patient. Your insurance company has an agreement with you (or your employer) and your **benefits** are based on this agreement. We will work with you to maximize your insurance benefits, however you are responsible for payment to us.
4. You understand that your dental insurance company **may** pay less for a procedure (based on your benefits agreement) than we bill and that you will be responsible for the full balance on your account. How much reimbursement and under what terms your insurance company pays for a procedure is based on your benefits agreement. You should have a copy of this agreement.
5. If you cancel your appointment 24 hours prior to the scheduled appointment time, no charge will be made to your account.
6. Failure to give 24 hours notice for cancellation or not showing for your scheduled appointment time will result in a charge of \$75.00 per hour of appointment time scheduled for you.
7. Statements will be mailed at your request, but for each statement mailed we will add a service charge of \$4.00 per statement mailed.
8. After insurance payment or decline, finance charges will be calculated on the last day of each month for balances over 30 days. The finance charge will be a periodic rate of 1.5% per month (18% APR).
9. Payment balances over 60 days will be considered in default. If you default on payment, you agree to pay the full balance due immediately (including interest and service charges). You also agree to pay for any and all collection costs and attorney fee's incurred to settle your defaulted balance.
10. Authorization to pay benefits directly to dentist. I hereby authorize payment to Lowell District Dental, P.C., or to Blake Street Dental, P.C. of the dental benefits otherwise payable to me.

Signature of Guarantor \_\_\_\_\_ Date \_\_\_\_\_

Name Of Guarantor \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Date \_\_\_\_\_

## TREATMENT AGREEMENT

DOB \_\_\_\_\_ Patient Name \_\_\_\_\_

Thank you for choosing us as your dental health care provider. We are committed to providing you with the finest quality dental services, that are consistent with your wants and needs. In order to provide safe, effective and informed dental treatment, proper information must be provided to you and your consent must be obtained.

**Treatment Consent Agreement** (you consent to the following)

1. I hereby authorize the dentist or designated staff to review my medical and dental records and I consent to a head, neck, oral examination and any other examination that is deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.
2. I hereby authorize the dentist or designated staff to take x-rays, photographs and any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.
3. Upon such diagnosis, I authorize the dentist or designated staff to perform all recommended treatment, **mutually agreed upon by me**, required to provide proper dental care.
4. I consent to the use of appropriate medications and therapies as deemed necessary. I consent to the use of local anesthetics and/or relaxation medications as deemed necessary. I fully understand that using these medications and therapies involve certain risks.
5. I realize that a successful outcome for my dental care requires that I follow all instructions and recommendations given by the dentist. I agree to follow these instructions and recommendations and accept responsibility for **all** outcomes when I do not follow instructions and recommendations.
6. I consent to allow the dentist to utilize any x-rays, photographs, study models or other information related to my diagnosis and/or treatment, for educational purposes or in scientific presentations. Any material will be presented in a completely anonymous manner.
7. Authorization to release information. Lowell District Dental, P.C. or Blake Street Dental, P.C. is authorized to provide any insurance company(s), claim administrators and consulting health care professionals information concerning my medical and dental records for evaluation of insurance claims benefits.
8. Authorization to consult other health care providers. Lowell District Dental, P.C. or Blake Street Dental, P.C. is authorized to consult with other health care professionals concerning my medical and/or dental records so as to facilitate my dental and health care.
9. Dental evaluations are essential to maintain good oral health. I accept that I am responsible for my oral health. I agree that I will see the dentist at least every six-(6) months and I agree to call the dental office for an evaluation if I have not seen the dentist in six-(6) months.

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Name Of Guardian \_\_\_\_\_ Relation to Patient \_\_\_\_\_