PERSONALIZED & COMFORTABLE
ARTISTIC SMILES
DENTISTRY

CONSENT FORM FOR GENERAL DENTAL PROCEDURES

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

Further, I understand that I am entering into a contractual relationship with Dr Czochanski, Dr. Kim-Czochanski or Dr. Khoo for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by Dr Czochanski, Dr. Kim-Czochanski or Dr. Khoo, I, agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Dr Czochanski, Dr. Kim-Czochanski or Dr. Khoo.

Furthermore, should a dental malpractice case or cause of action be initiated or pursued, I agree to use expert witness (es) who practice primarily in the same specialty as Dr Czochanski, Dr. Kim-Czochanski or Dr. Khoo. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the Academy of General Dentistry. In further consideration for this, Dr Czochanski, Dr. Kim-Czochanski or Dr. Khoo agrees to the same stipulations.

I acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Doctor's reputation and business. Both Dr Czochanski, Dr. Kim-Czochanski or Dr. Khoo and I agree in the event of a breach to allow specific performance and/or injunctive relief.

As with all healthcare treatment, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment
2. Infection in need of medication, follow-up procedures or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste
4. Damage to adjacent teeth, restorations or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need for replacement of restorations, implants or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist
9. A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery

Please turn over.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that Artistic Smiles Dentistry Inc. is not responsible for my dental treatment.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give permission to the Dentist to make any/all changes and additions as necessary.

I hereby authorize any of the doctors or dental auxiliaries of Artistic Smiles Dentistry to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

_____ _____

Patient Name Date Witness Date

_____ _____

Print Patient Name Date Parent/Legal Guardian Date

PERSONALIZED & COMFORTABLE
ARTISTIC SMILES
DENTISTRY

HIPAA PRIVACY RULE RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Acknowledgement of receipt of Information Practices Notice
§164.S20(a)

I _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

_____ _____
Signature of Individual or Legal Representative Witness

_____ _____
Printed Name of Individual or Legal Representative Date

I have received a copy of the Dental Materials Data Sheet.

_____ _____
Signature Date

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:
☐ Individual refused to sign
☐ Communication barrier prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Others (please specify)

_____
_____
_____

_____ _____
HPAA Officer Date

Please complete back page.

PERSONALIZED & COMFORTABLE
ARTISTIC SMILES
DENTISTRY

HIPAA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations §164.S08(a)

I _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information services as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

I authorize Artistic Smiles Dentistry to disclose my information to the following:

_____

_____

_____

PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations §164.S06(a)

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- this facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

_____ _____

Signature of Individual or Legal Representative Witness Date

_____ _____

Printed Name of Individual or Legal Representative Date

PERSONALIZED & COMFORTABLE
ARTISTIC SMILES
DENTISTRY

Welcome to our office. We believe that only when you are properly informed can you make a decision regarding your dental care. Please read about the following procedures and initial paragraph indicating you understand the statement. No procedure will be performed without your permission.

Name: _____

1. Drugs And Medications

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock.

Initial_____ **Date:** _____

2. X-rays

Proposed treatment: taking of intraoral and extraoral radiographs.
Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. They are also necessary for proper diagnosis and evaluation purposes.
Alternatives of treatment: none; limited visual examination.
Common risks: radiation exposure to soft and hard tissues.
Consequences of not performing the treatment: missed diagnosis.

Initial_____ **Date:**_____

3. Anesthetic

Proposed treatment: injection of anesthetic to surrounding oral tissues.
Benefits of treatment: numbness of tissue and muscle surrounding area of treatment to eliminate pain sensation.
Alternatives to treatment: dental restorations performed with no anesthetic resulting in severe sensitivity and pain.
Common risks: allergic reaction, irritation to nerve tissue, stiff or sore jaw joint, swelling of tissue, bruising and may cause temporary or permanent paralysis.
Consequences of not performing the treatment: severe pain and sensitivity.

Initial_____ **Date:**_____

4. Cleaning

Proposed treatment: involves thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal of *soft* plaque build-up and harder *calculus* deposits above and below the gum line.
Benefits of treatment: healthy oral environment; also, reduction/elimination of bleeding, odor and periodontal disease.
Alternatives of treatment: referrals for periodontal (gum) surgery according to the severity of condition.
Common risks: bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint.
Consequences of not performing the treatment: discontinued or interrupted treatment could result into further inflammation and infection of gum tissues, lead to more tooth decay, and deterioration of surrounding bone structure which could lead to tooth loss.

Initial_____ **Date:**_____

5. Dentures

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is require due to my delays of more than 30 days there will be additional charges.

Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____

6. Periodontal Loss (Tissue & Bone)

I understand that periodontal disease is a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. If I am diagnosed with periodontal disease, alternative treatment plans will be explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____

7. Removal of Teeth/Extraction

In the event I need to have teeth removal, alternatives to removal will be explained to me (i. e. root canal therapy, crowns and periodontal surgery, no treatment, etc.). I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socked, loss of fee ling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Proposed treatment: removal of unrestorable tooth structure and roots.
Benefits of treatment: elimination of pain, infection, swelling.
Alternatives of treatment: none.
Common risks: infection, bleeding, soreness, bruising, damage to adjacent teeth and soft tissue, dry socket, opening into sinuses, tooth and bone fragments, bone fracture, chronic hot and cold sensitivity, temporary and or permanent numbness, and destruction of bone and soft tissue.
Consequences of not performing the treatment*:* severe pain, swelling, infection, possible hospitalization with rare cases of death.

Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____

8. Endodontic Treatment (Root canal treatment and Pulpotomy)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost despite all effort to save it.

Proposed treatment: to remove infected pulp tissue and replace with root canal filling material.
Benefits of treatment: eliminate pain, infection, swelling and further destruction of tooth structure.
Alternatives of treatment: extraction.
Common risks: recurrence of symptoms, breakdown of tooth structure.
Consequences of not performing the treatment: increase in severity of pain, swelling, infection, and possible hospitalization and rare instances death.

Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____

9. Crowns, Bridges and Caps

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

Proposed treatment: to strengthen a tooth damaged by decay or previous restoration, and protect a tooth that has had root canal treatment. Improve the biting surface, appearance of damaged, discolored, poorly spaced and/or missing teeth.
Benefits of treatment: to restore or improve the appearance and strength of teeth.
Alternatives of treatment: extraction or Orthodontic treatment (only in proper spacing, not damaged teeth).
Common risks: irritation to surrounding tissue, inflammation, irritation to nerve tissue, stiff or sore jaw joint, sensitivity to hot and cold, also possible root canal treatment.
Consequences of not performing the treatment: further destruction, nerve exposure, loss of tooth function, root canal treatment.

Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____

10. Filling/Composites

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling/ composite than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly paced filling/composite.

Proposed treatment: to remove dental caries and replace with filling material to regain proper tooth anatomy.
Benefits of treatment: restore tooth structure for proper function.
Alternatives of treatment: temporary filling, crown, extraction.
Common risks: allergic to filling material, tooth sensitivity, filling may come out.

Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____
Initial_____ **Date:** _____	**Initial**_____ **Date:** _____	**Initial**_____ **Date:** _____

I have read and understood the entire information on this consent form, which includes drugs and medications, extraction, crowns, bridges and caps, endodontic treatment, periodontal loss, filling, dentures, x-rays, cleaning, and anesthetic. All my questions were answered to my full understanding and satisfaction.

_____ _____

Signature of patient, parent, or legal guardian Date

PERSONALIZED & COMFORTABLE
ARTISTIC SMILES
DENTISTRY

We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Cell Phone _____ Social Security # _____

Birthdate _____ eMail Address _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Name of nearest relative not living with you _____

Complete Address _____ Phone# _____

Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle) _____ (Marital Status) _____ (Driver Licence #)

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip) Home Phone _____

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip) How long at this address _____

Previous Address (if less than 3 years) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Social Security #_____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____ Work Phone _____

Spouse's Name _____ (Last) _____ (First) _____ (Middle) Relationship to Patient _____

Employer _____ Occupation _____ Yrs. Employed _____ Drivers Lic.#_____

Employer Address _____

Social Security #_____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Phone # _____

Is policy connected with your union? ○YES ○ NO Name of Union_____ Local No. _____

Do you have dual coverage? ○YES ○ NO**If yes: Please complete the following secondary insurance information.**

Insured's Name _____Insured's Soc. Sec. # _____

Insurance Co. _____Group No._____ Local No. _____

Insurance Co. Address _____ Phone # _____

Insured's Employer _____ Phone # _____

Dental Information

Are your teeth sensitive to heat or cold? ○YES ○ NO

Pressure?○YES ○ NO Sweet? ○YES ○ NO

Have you ever been diagnosed with a TMJ disorder? ○YES ○ NO

Do your gums bleed when you brush? ○YES ○ NO

Do you grind or clench your teeth? ○YES ○ NO

Do you have any fear of dental work? ○YES ○ NO

Do you have any clicking,popping or pain from the jaws or muscles of your head and neck? ○YES ○ NO

Date of last dental examination? _____ What was done at the time? _____

How would you describe your current dental problem?_____

How do you feel about the appearance of your teeth?_____

Please complete back page.

MEDICAL HISTORY

PATIENT NAME: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○YES	○NO	○N/A _____
Have you ever been hospitalized or had a major operation?	○YES	○NO	○N/A _____
Have you ever had a serious head or neck injury?	○YES	○NO	○N/A _____
Are you taking any medications, pills or drugs?	○YES	○NO	○N/A _____
Do you take, or have you taken, Phen-Fen or Redux?	○YES	○NO	○N/A _____
Do you or have you taken Fosomax, Boniva or any Bisphosphonate?	○ YES	○ NO	○ N/A _____
Are you on a special diet?	○YES	○NO	○N/A _____
Women:	○Pregnant/Trying to get pregnant	○Nursing	○Taking oral contraceptives

Are you allergic to any of the following?

○Aspirin ○Penicillin ○Codeine ○Acrylic ○Metal ○Latex ○Local Anesthetics ○Other_____

Do you have, or have you had, any of the following?

☐Aids/HIV Positive	☐Chest Pains	☐Frequent Headaches	☐Irregular Heartbeat	☐Scarlet Fever
☐Alzheimer's disease	☐Cold Sores/Fever Blisters	☐Genital Herpes	☐Kidney Problems	☐Shingles
☐Anaphylaxis	☐Congenital Heart Disorder	☐Glaucoma	☐Leukemia	☐Sickle Cell Disease
☐Anemia	☐Convulsions	☐Hay Fever	☐Liver Disease	☐Sinus Trouble
☐Angina	☐Cortisone Medicare	☐Heart Attack/Failure	☐Low Blood Pressure	☐Spinal Bifida
☐Arthritis/Gout	☐Diabetes	☐Heart Murmur*	☐Lung Disease	☐Stomach/Intestinal Disease
☐Artificial Heart Value*	☐Drug Addiction	☐Heart Pace Maker*	☐Mitral Valve Prolapse*	☐Stroke
☐Artificial Joint*	☐Easily Winded	☐Heart Trouble/Disease	☐Pain in Jaw Joints	☐Swelling of Limbs
☐Asthma	☐Emphysema	☐Hemophilia	☐Parathyroid Disease	☐Thyroid Disease
☐Blood Disease	☐Epilepsy or Seizures	☐Hepatitis A	☐Psychiatric Care	☐Tonsillitis
☐Blood Transfusion	☐Excessive Bleeding	☐Hepatitis B or C	☐Radiation Treatments	☐Tuberculosis
☐Breathing Problem	☐Excessive Thirst	☐Herpes	☐Recent Weight Loss	☐Tumors or Growths
☐Bruise Easily	☐Fainting Spells/Dizziness	☐High Blood Pressure	☐Renal Dialysis	☐Ulcers
☐Cancer	☐Frequent Cough	☐Hives or Rash	☐Rheumatic Fever*	☐Venereal Disease
☐Chemotherapy	☐Frequent Diarrhea	☐Hypoglycemia	☐Rheumatism	☐Yellow Jaundice

Have you ever had any serious illness not listed above? ○YES ○NO ○N/A _____

Comments: _____

_____

_____

CONSENT:

1. The undersigned hereby authorize doctor to take x-ray, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____ . I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due, and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-½% Finance charge (18% APR) may be added to my account.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Parent or Responsible Party_____

FOR OFFICE USE: Reviewed by Dr._____ Date _____