

Mt. Diablo Family Dentists  
Dr. Naina Jain DMD

**ACKNOWLEDGEMENT AND RECEIPT OF  
PRACTICE POLICIES**

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

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

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

\_\_\_\_\_ **INITIAL.** I HAVE RECEIVED A COPY OF THE DENTAL MATERIALS FACT SHEET.

**For Office Use Only:**

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

- Communication barriers prohibited us from obtaining the acknowledgement.
- Patient or Parent/Guardian refused to sign.
- An emergency prevented us from obtaining acknowledgement.
- Other: \_\_\_\_\_

**SIGNED:** \_\_\_\_\_

**DATE:** \_\_\_\_\_