

**Patient's Acknowledgement Form**

I, \_\_\_\_\_, acknowledge that I received and reviewed the office Privacy Policy Notice for Paul Geller DDS.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

In case you do not agree to sign this form, our office must indicate why you declined to do so.

Reason for patient's refusal:

\_\_\_\_\_

Privacy Director's signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

I hereby grant consent for Dr. Paul Geller and staff to perform a clinical dental examination, including needed radiographs, study models, prophylaxis and basic restorative dentistry.

Patient's or guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_