

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ DATE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
 SSN \_\_\_\_\_ DOB \_\_\_\_\_ MARITAL STATUS S M D W  
 HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ REFERRED BY \_\_\_\_\_  
 IF MINOR, NAME OF GUARDIAN \_\_\_\_\_ ADDRESS & TELEPHONE \_\_\_\_\_  
 RELATIONSHIP TO PATIENT \_\_\_\_\_ SPOUSE EMPLOYMENT PHONE \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_ WILL YOU RECEIVE CALLS AT WORK? \_\_\_\_\_  
 EMPLOYERS NAME & TELEPHONE # \_\_\_\_\_

EMERGENCY NOTIFICATION NAME & NUMBER \_\_\_\_\_  
 Nearest relative not living with you \_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF INSURANCE COMPANY \_\_\_\_\_ TELEPHONE # \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ INSURED'S NAME \_\_\_\_\_  
 GROUP # \_\_\_\_\_

Dr. Paul Caputo, DDS  
 3490 East Lake Road #A  
 Palm Harbor, Florida 34685  
 (727) 789-1333

**Notice of Privacy Practices  
Patient Acknowledgement**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I have received this practice's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time at the address above to obtain a current copy.

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

Relationship to patient (if signed by personal representative of patient)

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices notice, but was unable to do so as documented below:

Date	Initials	Reason