



# Fina Family Dental, PLLC

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<http://finafamilydental.com>

Patient Name (print): \_\_\_\_\_

## CONSENT FOR DENTAL TREATMENT

I hereby authorize the above-named dentist to perform dental treatment such as extractions and restorations and to administer injection of pharmaceutical products and medication as in the judgment of the above is deemed necessary.

\_\_\_\_\_  
Patient's signature

(Parent or Guardian, if minor)

\_\_\_\_\_  
Date

## ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

I (*print name*) \_\_\_\_\_ acknowledge that the above named office will keep my medical information private and that I am entitled at any time to receive a copy of this office's Privacy Practices.

\_\_\_\_\_  
Patient's signature

(Parent or Guardian, if minor)

\_\_\_\_\_  
Date

### FOR DENTIST OFFICE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not for the following reason:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (explain)

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