

Welcome to Eastern Virginia Pediatric Dentistry

*We strive to make your child's visit pleasant and comfortable.
Our goal is to teach your child oral habits that will keep their smile beautiful for a lifetime.*

DATE: ___/___/___
MM DD YY

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____ Nickname: _____

Age: _____ Date of Birth: ___/___/___ Male Female Other

School: _____ Grade: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Hobbies/Interests: _____

► Whom may we thank for referring you to our practice?

PARENT/GUARDIAN INFORMATION

Parents' Marital Status: Married Divorced Single Separated Widowed

► MOTHER FATHER STEPPARENT LEGAL GUARDIAN FOSTER PARENT

Last Name: _____ First Name: _____ Date of Birth: ___/___/___

SSN: ___ - ___ - _____ Employer: _____ Work # (____) ___ - _____

Does this person hold insurance for this child? Yes No

Address (if different than patient): _____

Home # (____) ___ - _____ Cell # (____) ___ - _____ Email: _____

Additional Parent/Guardian Information:

► MOTHER FATHER STEPPARENT LEGAL GUARDIAN FOSTER PARENT

Last Name: _____ First Name: _____ Date of Birth: ___/___/___

SSN: ___ - ___ - _____ Employer: _____ Work # (____) ___ - _____

Does this person hold insurance for this child? Yes No

Address (if different than patient): _____

Home # (____) ___ - _____ Cell # (____) ___ - _____ Email: _____

PRIMARY DENTAL INSURANCE

Dental Insurance Company Name: _____ Group # _____

Insurance Subscriber's/Policy holder's Name: _____ Relationship to child: _____

Date of Birth: ____ / ____ / ____ SSN: ____ - ____ - ____ Subscriber/Policy Holder # _____

Employer: _____

SECONDARY DENTAL INSURANCE (IF APPLICABLE)

Dental Insurance Company Name: _____ Group # _____

Insurance Subscriber's/Policy holder's Name: _____ Relationship to child: _____

Date of Birth: ____ / ____ / ____ SSN: ____ - ____ - ____ Subscriber/Policy Holder # _____

Employer: _____

ACCOMPANYING YOUR CHILD

A parent or legal guardian must be present during all treatment appointments unless the authorized person is listed below or a signed letter is provided.

Please list any person(s), other than legal parents/guardians, who are authorized to accompany your child and are authorized to make medical decisions on the legal guardians behalf.

Last Name: _____ First Name: _____ Relation: _____

Last Name: _____ First Name: _____ Relation: _____

Last Name: _____ First Name: _____ Relation: _____

Authorized person(s) must present proper identification upon arrival.

None – only legal parents/guardians may accompany my child

DENTAL AND HEALTH HISTORY

Your child's overall health and any medication that he/she takes could have an important interrelationship with the dental care he/she receives. This section will be updated (i) when analgesia, sedation, and/or anesthesia are to be administered; (ii) when medically indicated; and (iii) annually. Please answer each of the following questions completely.

▪ Why did you bring your child to the dentist today? _____

▪ Is this your child's first visit to the dentist? Yes No

▪ If not, when was your child's last visit to the dentist? _____ Name of Previous Dentist: _____

▪ Were x-rays taken at previous dental visits? Yes No

▪ Has your child had difficulty with previous dental visits? Yes No If yes, please explain: _____

▪ Has your child been hospitalized? Yes No If yes, please explain: _____

▪ Is your child allergic to or made sick by penicillin, aspirin, codeine, or any other medications? Yes No

If yes, please list: _____

▪ Has your child had a history of problems with any of the following? (***Check all that apply***)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Wheelchair Bound |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other? _____ |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Organ Transplant | _____ |
| <input type="checkbox"/> Cancer-Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Pain In Jaw Joints | _____ |
| | <input type="checkbox"/> HIV+/AIDS | | |

▪ Please list any medical conditions, diseases, or problems that your child has if it is not listed above: _____

▪ Please list any medications your child is currently taking: _____

▪ Name of Child's Primary Care Physician: _____

► CHILD'S HABITS

- Does your child brush his/her own teeth? Yes No When does he/she brush? AM PM After Meals
- Do you assist in brushing your child's teeth? Yes No
- Does your child floss daily? Yes No

- | | |
|---|--|
| ◦ Does your child take fluoride supplements? Yes <input type="checkbox"/> No <input type="checkbox"/> | ◦ Is your child currently breast fed? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| ◦ Does your child use a sippy cup? Yes <input type="checkbox"/> No <input type="checkbox"/> | ◦ Does your child sleep with a bottle? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| ◦ Does your child suck his/her thumb or finger(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> | ◦ Does your child use a pacifier? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| ◦ Does your child grind his/her teeth? Yes <input type="checkbox"/> No <input type="checkbox"/> | ◦ Does your child chew hard objects (pencils etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/> |

Authorization and Release

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to my child during the period of dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

► SIGNATURE OF PARENT/GUARDIAN _____ **DATE:** ____ / ____ / ____
MM DD YY

FINANCIAL AND GUARANTOR AGREEMENT

PLEASE READ CAREFULLY!

Please understand that we file insurance as a courtesy to our patients. Your insurance policy is a contract between you, your employer, and your insurance company, and not our dental office. We have no control over the terms of your contract, the methods of reimbursement, or the determination of benefits. All insurance companies are different, and you are responsible for knowing your provisions.

► FEES, PAYMENTS, AND INSURANCE

- We are a fee for service practice and payment is expected at the time of service.
- The parent bringing the child to the dentist is the responsible party for payment. Please come prepared with your payment as we will not bill any other party for services rendered.
- If you have insurance, please be advised that your estimated copayment is due at the time of your child's dental visit.

► 24 HOUR NOTICE POLICY

- In the event you are unable to come at your appointed time, please notify us at least 24 hours in advance of your appointment. Cancellations made less than 24 hours before the scheduled appointment time will be considered untimely and may be subject to a cancellation fee.
- Two or more missed appointments or untimely cancellations will result in the termination of your child's dental care in our office.
- If you arrive to your appointment more than ten (10) minutes late, we reserve the right to only complete the services we have time to complete and/or to reschedule your appointment.

► MISCELLANEOUS

- All paperwork, including medical history, patient information, and consent forms, must be completed by a parent or legal guardian.
- **Pre-sedated and pre-school age patients will be appointed between the hours of 8 AM and 12 PM.**
- Due to space limitations, when you are accompanied by other children who do not have dental appointments, please remain in the waiting room with those children.

I have read and fully understand the above Financial and Guarantor Agreement and accept all provisions. I am also aware that by signing below I am financially responsible for this account.

► SIGNATURE OF PARENT/GUARDIAN: _____ DATE: ____ / ____ / ____
MM DD YY

FINANCIAL AGREEMENT

If you do not have insurance, the parent/legal guardian is financially responsible for the entire payment upon completion of the appointment.

DENTAL INSURANCE As a courtesy, we will be happy to help you file your insurance claims. You must provide us with all the information necessary to verify your child's eligibility and to file your claim. **Remember your insurance policy is an agreement between you and the insurance company. *Our practice is not a party to that agreement.*** Though we may estimate your insurance benefits, we are not responsible for its accuracy. Knowledge of benefits, as well as benefit amounts, limitations, exclusions, waiting periods, etc. is **your** responsibility. Receiving our services indicates acceptance of responsibility to pay regardless of our estimate. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits *differ* from one insurance company to another. Fees for non-covered services, including deductibles and copayments, are due at the time of service. We can file a pre-determination for recommended treatment. We strongly suggest that you contact your insurance company with any questions you may have. Again, we will help file your insurance as a courtesy to you.

PAYMENT We accept cash, check, Visa, MasterCard, Discover, and American Express. By law, your insurance company is required to pay each claim within 30 days. After dental insurance has paid its portion, a statement for the remaining balance will be sent to your mailing address on record. *If payment is not made upon receipt of our statement, we will no longer file your insurance and expect payment in full at the next time of service.* If we have not received payment from your insurance company 60 days after services are rendered, you will be responsible for the full account balance.

MONTHLY STATEMENT If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the account, and any payments or credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment; **we cannot send statements to other persons.**

COLLECTION POLICY If your account becomes delinquent and no financial arrangements have been made, you will be responsible for legal fees, interest charges, and any other expenses incurred in collecting your account balance. All work must be paid in full at the time of service once your account has been satisfied with the attorney.

MINOR PATIENTS The parent or guardian accompanying the minor is responsible for the full payment. In the case of *divorced* or *separated* parents, the parent accompanying the child is responsible for payment. This office will not attempt to collect payment from a parent that is not present in the office at that visit. If the divorce decree requires the other parents to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS FINANCIAL AGREEMENT.

PATIENT(S) NAME(S)

PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY (PRINTED)

PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY (SIGNATURE)

RELATIONSHIP TO PATIENT(S) _____ DATE ____ / ____ / ____
MM DD YY

CONSENT FOR DENTAL TREATMENT

Patient Name: _____ DOB: _____

1. I request and authorize Dr. Shapiro, Dr. Morgan, and staff to perform or assist in the performance of the following but not necessarily limited to:
 - Emergency Dental Treatment
 - Fillings
 - Cleanings, X-rays, Fluoride treatments
 - Sealants
 - Extractions/Oral Surgery
 - Space Maintenance/Interceptive Orthodontics
 - Crowns
2. The purpose of the above is to maintain dental health, and we anticipate that result. No guarantees or assurances can be made as to the results that may be obtained.
3. Bleeding, swelling, discomfort and bruising can occur after any dental procedure. The risk of not completing necessary dental treatment can result in abscess, infection, pain, fever, swelling and substantial risk to the developing permanent teeth.
4. I understand that unforeseen conditions or circumstances may arise during the course of the above-described procedure or treatment. Hence, I consent to and authorize the performance of any care, procedure, or treatment not specified above that the dentist reasonably believes necessary or advisable as a result of these unforeseen events.
5. I understand that to facilitate my child's treatment a sedative may be required. I understand that sedation may prove partially or completely ineffective.
6. Additionally, I consent to the administration of local anesthetic that the dentist deems necessary, and/or nitrous oxide. I understand that the risks involved with the administration of local anesthetics may also be characterized by excitation, depression, nervousness, dizziness, blurred vision, tremors, drowsiness, and convulsions (seizures). Allergic reactions may occur which may be characterized by skin eruptions, itching, and swelling. I understand that the alternative of not using local anesthetic would probably cause a great deal of discomfort. The risk of this alternative could be emotional damage.
7. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand that treatment in terms appropriate for their age. To accomplish this, the patient's behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.
8. **I understand that I may refuse any and all treatments.** I have crossed out and initialed anything that I would refuse to consent to.
9. I certify that I have read and understand the above. I accept the risk of substantial and serious harm, if any, in hope of obtaining the desired beneficial results of this treatment or procedure
10. I understand that I am responsible for all fees incurred in relation to this child. This office will also assist in the prompt filing of all insurance forms as it applies.

By signing below, I certify that I am the legal parent, guardian, or personal representative of the patient, and there are no court orders in effect that prevent me from signing this consent.

PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY (SIGNATURE)

RELATIONSHIP TO PATIENT(S): _____ **DATE:** ____ / ____ / ____



Eastern Virginia Pediatric Dentistry

A Division of Atlantic Dental Care, PLC

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757.627.7550

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends, or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative.

If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information

Required by Law. We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

Your Rights Regarding Your Protected Health Information

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will

Law Enforcement. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

Workers’ Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs established by law.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION

Dr. Nathan Shapiro
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1806 Hampton Blvd, Ste A, Norfolk, VA 23517
Email: officemanager@evapd.com



Eastern Virginia Pediatric Dentistry

A Division of Atlantic Dental Care, PLC

**1806 Hampton Boulevard, Suite A • Norfolk, Virginia 23517
757.627.7550**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

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