APOLLONIA DENTAL

Thank you for choosing Apollonia Dental for your biological (also known as "holistic") dental needs. In order to best serve you, we will be collecting key pieces of information. Please answer all questions to the best of your knowledge, and do not skip anything, as this could interfere with the effective handling of your insurance claims, statements, communication(s) with referring doctors and/or the proper care you receive from Dr. Dunnington and her staff.

Today's Date _____/_____/_____

_____(_____) _____

Last Name First Name Preferred Name Email

_____/_____/_____ _____-_____-_____ (_____) _____-_____ (_____) _____-_____

Date of Birth SSN Phone (Primary) Phone (Secondary)

_____

Mailing Address City State Zip

How did you hear about us? Google Facebook Doctor/Existing Patient _____

_____ (_____) _____-_____ _____

Emergency Contact Name Phone (Primary) Relationship to Patient

_____ (_____) _____-_____ _____

Pharmacy Name Pharmacy Phone Address/Cross Streets

_____ (_____) _____-_____ _____

Dental Insurance Co Name Phone (for Dental Providers) Member/Subscriber ID#

_____ _____/_____/_____ _____

Subscriber Name (If other than yourself) Subscriber dob Subscriber's Employer

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On a scale of 1-10, *10 being **best***, *1 being **worst*** how would you rate your

General Health	1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Dental Health	1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Past Dental experiences	1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

***My most recent dental cleaning/visit to a dentist other than Apollonia was on/around*:** _____

What are your 3 main concerns pertaining to your dental health and/or your oral contributions to your overall health?

1. _____
2. _____
3. _____

Are you taking any medications for Osteopenia/Osteoporosis or Bone Disease?

☐ Yes ☐ No

Have you taken or are you taking Fosamax, Boniva or any other Bisphosphonate Drug in the past?

☐ Yes ☐ No

Do you have your gallbladder?

☐ Yes ☐ No

Please list all *medications* or *supplements* currently being taken including but not limited to the following:

- Antibiotics
- Anticoagulants
- Barbiturates
- Anti-Depressants
- Blood Thinners
- Osteoporosis Med.
- Cortisone/Steroids
- Sleeping Medications
- Diet Pills
- Heart Medication
- Insulin
- Stomach Med.
- Muscle Relaxants
- Nerve medications
- Pain Medications
- Cholesterol Med.

☐ **Check this box if you are not taking any medications or supplements.**

Name	Dosage/Frequency	Purpose	Additional info

***Additional medications or supplements may be written in the last page of this form.**

Please circle or add any medications or substances that have caused an allergic reaction:

☐ **Check this box if you do not have any *known* allergic reactions.**

Known Allergies to:	Specific Reaction:	Additional Information:
Antibiotics		
Aspirin		
Barbiturates		
Codeine		
Iodine		
Latex		
Local Anesthetic		
Metals		
Penicillin		
Plastics		
Sedatives		
Sulfa Drugs		

*****Additional allergies and specific reasons may be written in the last page of this form.**

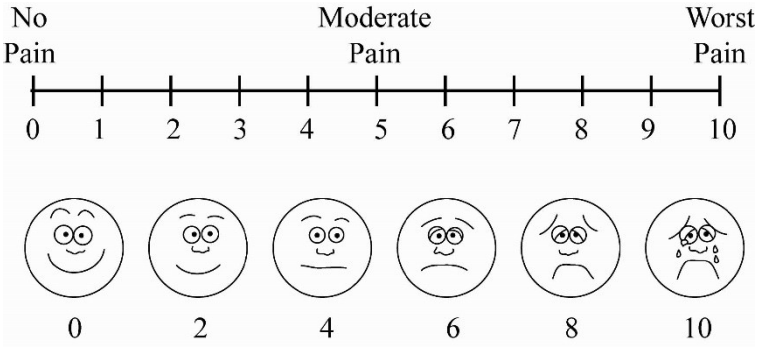
Please list your other doctors and healthcare professionals below:

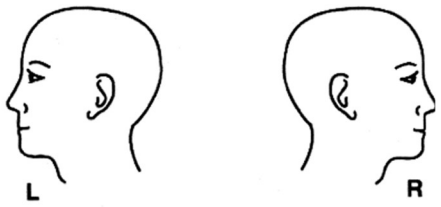
Name	Specialty	Type of Treatment	Phone Number	Last Visit

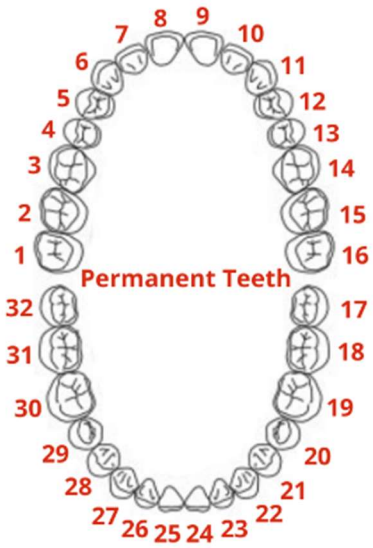
*****Additional doctors and healthcare professionals may be written in the last page of this form.**

1) Please mark (X) any areas of pain, discomfort, or concern that you are feeling.
2) Write *a number* to indicate the severity it feels on that spot or area as follows:

3) ☐ *Check this box if you do not have any pain, discomfort, or concerns.*







Please circle all that apply to you.

Teeth	**Mouth**	
Broken teeth	*Bad bite*	*Overbite ("bucked teeth")*
Chipped/worn teeth	Burning tongue	*Persistent/Wandering dental sensitivity*
Crowded teeth	*Deep overbite (weak chin)*	*Prior orthodontics*
Discolored	Difficulty Swallowing	*Scratchy, itchy throat*
Frequent cavities	*Dry mouth and/or lips*	Sore throat without infection
History of teeth extraction for braces/orthodontics	Feeling of object in throat	Sour/Bad taste
I DO NOT like my smile	Frequent coughing or clearing	*Speech difficulty*
I want to change my smile	*Frequent sore throat*	*Sunken lips and reverse smile curve (sad look)*
Injury to teeth	*History of lots of dental work*	*Throat infections*
Lingual bar(s) after braces	*Inability to find bite*	*Tongue has teeth prints on side (scalloping)*
Missing teeth	*Injury to mouth*	*Tongue-tie or history of tongue-tie release*
Spacing	*Mouth breathing*	*Tonsils removed*
Teeth grinding	Mouth discomfort	*Underbite ("bulldog jaw")*
Wisdom teeth extracted	*On-going myofunctional therapy*	

Gums	**Habits**	**Digestion**
Bad Breath	Cheek/Lip biting	*Acid reflux*

Bony outgrowth on palate or inside lower jaw (Tori and/or Exostosis)	Chew on ice/hard objects	*Bloating/Bloating after meals*
Gums bleeding	E-cigarettes or vaping	*Cannot tell if feeling full or not after eating or drinking*
Gum recession	Finger Sucking	*Food intolerance*
Gums Swollen	History of alcohol abuse	Intestinal disorder
Painful	History of drug abuse	*Poor digestion*
Periodontal Disease	Nail-biting	*Poor stool elimination*
Ulcers	Use tobacco products	

Jaw	**Head & Face**	**Neck, Shoulders & Back**
Abnormal/Limited mouth opening	Back of the head aches	*Double chin*
Clicking or Popping sound from jaw joint	Dizziness	*Female: neck size > 15 in.*
Grinding sound in jaw joint	*Forehead headaches*	*Forward head posture (ears ahead of shoulders)*
Jaw clenching	*Injury to face*	*Injury to neck*
Jaw joint injury	*Migraine-type headaches*	*Lack of mobility*
Jaw joint pain	*Morning headache*	*Lower jaw & chin bulge*
Jaw locks open/shut	*Scalp tender to touch*	*Male neck size > 17 in.*
Jaw pain	*Severe headaches*	*Neck, shoulder, and/or back pain*
Locking jaw joints	*Sinus Headaches*	*On-going chiropractic, cranio-sacral, or other body therapy*
Pain in cheek muscles	*Temporal headaches*	*Stiffness*
Sore jaws	*Tension Headaches*	*Tired/Sore neck muscles*
Uncontrollable jaw movement	Other (specify):	Other (specify):
When opening or closing mouth, jaw deviates or deflects from center line		

Ears	**Nasal**	**Eyes**
Balance problems	Allergies	Bloodshot eyes
Clogged/stuffy feeling in ears	*Post-nasal drainage*	*Blurred vision*
Decreased hearing	*Shortness of breath*	Dark circles under eyes
Ear pain without infection	*Sinus infection*	Glaucoma
Frequent ear infection	Sinus pain	Pain in/around/behind eyes
Hearing impairment	*Sinus problems*	Pressure behind eyes
Itchy feeling in ears	*Stuffy/runny nose, post-nasal drainage, or other sinus issues*	Sensitivity to light
Ringing/Buzzing in ears		Tearing of eyes
Tubes in ears		*Visible white space (sclera) under iris of eyes*
Sleep		
CPAP machine to sleep	*Insomnia*	*Sleep test diagnosed obstructive sleep apnea*

Daytime sleepiness/fatigue	*Lethargy / Feel unenergized after waking up in the morning and/or most times*	*Snoring/Snoring reported to you by others*
Gasping for air / choking in sleep	*Sleep apnea (suspected)*	*Trouble/Restless sleeping*

Please circle all that apply to you. Write in any important details as needed.

ADD/ADHD - hyperactive	
Adenoids removed	
Anemia	
Anxiety	
Arm/Finger pain/numbness	
Arteriosclerosis	
Asthma	
Autoimmune disorder	
Autoimmune disorder/disease (specify) -	
Bleed easily	
Bruise easily	
Cancer	
Chemotherapy	
Chronic fatigue	
Cold hands / cold feet	
Current pregnancy	
Depression	
Difficulty focusing	
Emphysema	
Epilepsy	
Erectile dysfunction	
Excessive thirst	
Fluid retention	
Foggy/Senile memory	
Frequent colds	
Frequent illness	
Frequent stress	
Gout	
Grouchiness/Bad mood	
Hair loss	
Hay fever	
Heart arrhythmia	
Heart disease	
Heart disorder	
Heart murmur	
Heart pacemaker	
Heart palpitations	
Heart valve replacement	
Hemophilia	
Hepatitis	
High blood pressure	

History of physical injury/trauma from accident/incident (specify) -	
HIV/AIDS	
Hypoglycemia	
Hypothyroidism	
Immune disorder	
Joint replacement	
Kidney problems	
Lack of coordination	
Liver disease	
Low blood pressure	
Low libido/sex drive	
Meniere's disease	
Mitral valve procedure	
Multiple sclerosis	
Muscle aches	
Muscle cramps	
Muscle tremors	
Muscular dystrophy	
Nervous irritability	
Nervousness	
Neuralgia	
Numbness of hands, feet, arms, and/or legs	
Osteoporosis	
Parkinson's disease	
PMS	
Poor circulation	
Pot belly	
Psychiatric care	
Radiation treatment	
Rheumatic fever	
Rheumatoid arthritis	
Scarlet fever	
Skin disorders	
Slow healing sores	
Stroke	
Swollen calf muscles	
Swollen joints	
Thyroid disease	
Tuberculosis	
Tumors	
Type 1 Diabetes	
Type 2 Diabetes	
Urinary disorders	
Waking up to urinate more than once	
Weight gain	

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.
(Even if you have not done some of these things recently, try to work out how they would have affected you.)

Use the following scale to choose the most appropriate number for each situation.

SITUATION (*check ☑ the box*)	**No chance of dozing**	**Slight chance of dozing**	**Moderate chance of dozing**	**High chance of dozing**
Sitting and reading	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Watching TV or a movie	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Sitting inactive in a public space (e.g. theater, meeting, park, etc.)	☐ (0)	☐ (1)	☐ (2)	☐ (3)
As a passenger in a car for an hour without a break	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Lying down to rest in the afternoon when circumstances permit	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Sitting and talking to someone	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Sitting quietly after a lunch without alcohol	☐ (0)	☐ (1)	☐ (2)	☐ (3)
In a vehicle, while stopped for a few minutes in traffic	☐ (0)	☐ (1)	☐ (2)	☐ (3)

Internal Use Only:

Total Points Epworth Sleepiness Scale = _____

1 to 6 = sufficient sleep
7 to 8 = average
9 and up = sleep specialist referral

*****You may write in any additional information, medications, supplements, and/or allergies and specifics below.**

_____
_____
_____
_____
_____
_____
_____

Thank you for completing your information! We look forward to helping you achieve your total wellness goals!

I certify that the above information and health history is true and correct to the best of my knowledge.

Name (Printed)

Signature **Today's Date**

Dr. Katharine C. Dunnington
9501 N Western Ave
Oklahoma City, OK 73114
(P) 405.463.4500 (F) 405.972.3025

APOLLONIA DENTAL

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Initial _____

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked. Initial _____

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties' consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law,

(continued on next page)

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APOLLONIA DENTAL

ARBITRATION AGREEMENT continued

where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement. Initial _____

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. Initial _____

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties. Initial _____

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), arbitration shall be effective as of the date of first professional services. Initial _____

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL/MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

I hereby agree to have ANY issue of dental/medical malpractice decided by neutral arbitration and give up my right to a jury or court trial.

_____ _____

Print Name Signature & Date

APOLLONIA DENTAL

HIPAA

Notice of Privacy Practice

This notice describes how medical / dental information about you may be used/disclosed and how you can get access to this information. Please review it carefully. Our commitment here at Apollonia Dental is to serve our clients with professionalism, assuring at all times the protection of privacy and security of all Protected Health Information. When you receive care from Apollonia Dental, we may use your health information for treating you, billing for services, and conducting our normal business known as dental care operations. Examples of how we use your information include:

Treatment: We may use and disclose your dental information to plan, provide and coordinate your dental care services. For example, we may make your dental information available to other providers for review of treatment options or to enable them to schedule visits appropriate for review of treatment options or to enable them to schedule visits appropriate for your treatment.

Payment: We may use and disclose your dental information and records to obtain payment for dental services we have provided for you. For example, we may provide copies of notes and x-rays made during your visit to the appropriate insurance company to enable them to make payment for services you received.

Health Care Operation: We may use or disclose your protected health information for our health care operations. For example, we may use or disclose your personal health information to perform risk assessments and other administrative tasks to monitor the quality of care we provide. For uses and disclosures of your personal dental information not involving treatment, payment of health care operations, we will receive your written authorization prior to using or disclosing any personal health information (unless required or permitted by law). You have the right to revoke any authorization previously granted.

We may use and disclose your personal health information without obtaining your consent or authorization in the following situations:
- To recommend treatment alternatives
- To tell you about dental services and products that may benefit you.
- To remind you of an appointment
- Share information with third parties who help us with treatment, payment, and other health operations. Our business associates must follow our privacy practices.
- Share information with family or friends involved in your care or payment for your care provided. You have the opportunity to agree or object to this disclosure. If you are unable to agree or object, we may disclose information as necessary based on our professional judgment.
- For health oversights activities such as investigations, audits, and inspections as authorized by law.
- For lawsuits and similar proceedings when we receive satisfactory assurance that appropriate precautions have been taken.
- When requested by law enforcement as required by law or court order. - When otherwise required by law.

Apollonia Dental is Required by Law To:
- Maintain the privacy of your health information.
- Provide this notice that describes the ways we may use and share your information.
- Follow the terms of the notice currently in effect.

You Have The Right To:
- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restrictions.
- Inspect and copy your health information, including dental and billing records. Fees may apply. Under limited circumstances, we may deny your access to a portion of your health information, and you may request a review of the denial. *

Requests marked with a star (*) must be in writing.
We reserve the right to change or privacy practices and to alter this Notice according to those changes; we will provide a copy of the changes to you at your next schedule appointment.

I understand and agree to the above-described privacy policy.

_____ _____

Printed Name Signature

APOLLONIA DENTAL

We are pleased that you have insurance benefits to help with the cost of your orofacial care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work together to maximize this benefit.

I understand that I am responsible for the estimated amount not paid by the insurance company on the day services are rendered. Unless financial agreement has been made in advance with our office manager.

If after billing and contacting the insurance company more than three times, and payment has not been received, we will detach the insurance claim and make the patient fully responsible for the balance.

I understand that after the insurance company pays Apollonia Dental, there could still be a balance for which I am responsible to pay in full upon receipt of the updated billing statement.

I understand that if my account goes to a collection agency, I will be responsible for all fees associated with the collection of my account.

My signature below confirms I understand I am fully responsible for the full fee for treatment performed regardless the outcome from my insurance company's processing of my claim.

My signature below authorizes Apollonia Dental to release information to my insurance company necessary to receive dental benefits.

My signature below also gives my authorization for payment directly to Katharine Dunnington, DDS.; insurance benefits otherwise payable to me.

It is our goal to help you receive the most out of your dental benefits. As a courtesy, we submit your insurance forms for you and allow assignment of benefits to us. As much as it is our goal to help with your insurance reimbursement, we must point out that your insurance is an agreement between you, your employer, and the insurance company. We are not a party to this agreement. Though we can be helpful with your insurance questions, we do not have the authority to make insurance decisions on your behalf. We cannot be responsible for the insurance company decisions about payment; this is between you, your employer, and the insurance company. Please take the time to understand your group's dental insurance limitation, maximum, deductible, exclusions etc.

□ The check mark in the box indicates I do not have dental insurance & understand I am responsible for payment in full at the time of service unless other arrangements have been made prior to my treatment.

Signature: _____ Date: _____

APOLLONIA DENTAL

Payment for treatment rendered is **due at the time of service**. We accept MasterCard, VISA, and American Express. If you are in need of an extended finance option, we also offer CareCredit.

We welcome you and look forward to helping you achieve your wellness goals. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

To reserve my initial appointment, I understand there is a $200, nonrefundable fee. This will be applied to the cost of data gathering (x-rays, exam, tests, etc.).

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Apollonia Dental.

We appreciate the trust you have placed in us by choosing our dental practice. In order to make your experience smooth and pleasant, we ask that you read and acknowledge our financial policy.

Payment is due at the time of service. Cash and personal checks are accepted. A 5% courtesy will be extended for full cash (or check) payment in advance. A $25 fee will be charged for returned checks. If an extended payment plan is desired, we offer CareCredit. MasterCard, VISA, and American Express credit card payments are also welcome. If you have any questions, please feel free to ask.

INITIAL HERE _____

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable.

INITIAL HERE_____

I understand that if I make an appointment, I am responsible for keeping that appointment. In the event that I cannot make an appointment, I understand that I must provide at least 24 hours' notice. If an appointment of 2hours or greater is necessary, I agree to pay $200 to reserve the appointment. I understand the $200 will be applied toward the cost of treatment provided during the appointment . INITIAL HERE____

We suggest and encourage you to discuss office visit and procedural costs at the time of service to avoid misunderstandings. Failure to do so does not absolve you of responsibility for charges incurred.

INITIAL HERE _____

I understand that there is a charge for all dental services and consultations with Dr. Dunnington.

INITIAL HERE _____

_____ _____

Print Name Signature & Date

Dr. Katharine C. Dunnington
9501 N Western Ave
Oklahoma City, OK 73114
(P) 405.463.4500 (F) 405.972.3025

APOLLONIA DENTAL

Missed Appointment & Cancellation Policy

Dear Apollonia Dental patients,

At Apollonia Dental, our primary goal is to provide you with the highest standard of care and service. To ensure that we can continue to offer this level of care to all of our patients, we have implemented a cancellation policy for all scheduled appointments.

Effective immediately, our cancellation policy is as follows.

1. **Notice Period:** We require a minimum of 3 business days' notice of your inability to attend your scheduled appointment. NOTE: if you have an appointment on a Monday we must be informed on the Wednesday prior. If you have an appointment on a Tuesday, we require you to inform on the Thursday prior.
2. **Cancellation fee:** If an appointment is cancelled or rescheduled with less than 3 business days' notice, a cancelation fee of $150 will be charged to the card we have on file. This fee helps cover the costs associated with the time reserved for you.
3. **No-Show Policy:** Patients who do not show up for their scheduled appointment without any prior notice will also be subject to the cancellation fee of $150, and will not qualify for a return on their reservation fees.
4. **Exceptions:** We understand that emergencies and unforeseen circumstances can arise. Please contact our office as soon as possible if you are unable to keep your appointment. We will assess these situations on a case-by-case basis and may waive the cancellation fee at our discretion.

We appreciate your understanding and cooperation with this policy. Our intention is to minimize disruptions and ensure that all patients have access to timely dental care. If you have any questions or concerns regarding this policy, please do not hesitate to contact our office at (405)463-4500 or info@apolloniaholisticdental.com.

Thank you for being a valued patient of Apollonia Dental. We look forward to continuing to serve you healthcare and dental needs.

Sincerely,

Dr. Katharine C. Dunnington

Print: _____ Date: _____

Sign: _____

Rev May 6, 2025

APOLLONIA DENTAL

Patient Photo Release Form

I hereby authorize Dr. Dunnington and/or any of her assignees to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, and professional publications (dental magazines and journals).

I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____