Health History Form

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle | Home Phone: ( ) | Work Phone: ( ) | Cell Phone: ( )

Address: Mailing address | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Would you like to sign for our monthly Health News Letter (Sent via email only once a month)? Yes ☐ No ☐

List all the countries you have visited in the past 12 months?

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment? If yes, please describe below.	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have ear aches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental visit: _____
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If yes, what was the illness or problem?

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Sleep Apnae Questionnaire

	Yes	No	DK
Has anyone told you that you that you snore?	☐	☐	☐
Do you often feel tired, fatigued or sleepy during day time?	☐	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐	☐
Do you have or are you being treated for high blood pressure?	☐	☐	☐
BMI more than 35?	☐	☐	☐
Age over 50 years old?	☐	☐	☐
Neck circumference more than16 inches?	☐	☐	☐
Gender: Male?	☐	☐	☐

(*Please refer to Obstructive Sleep Apnae (OSA) Brochure for details)

High risk of OSA: Yes 5-8
Intermediate risk of OSA: Yes 3-4
Low risk of OSA: Yes 0-2

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much do you typically drink In a week? _____

WOMEN ONLY Are you:

	Yes	No	DK
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:

To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus.	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: | Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:	☐	☐	☐

NOTE: Both Doctor and patient are encouraged to discuss any and all patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments: _____

_____

_____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

2220 Coit Rd. Ste. 570
Plano, TX 75075
Ph: 972-964-6500
Fx: 972-964-6511

Patient:_____ **DOB:**_____ **BP:**_____
Dentist:_____ **Pulse:**_____

1. WORK TO BE DONE: I understand that I am having the following work done (indicate all services being provided): ( ) Fillings, ( ) Bridges, ( ) Crowns, (X) X-rays, ( ) Extractions, ( ) Impacted Teeth Removal, ( ) Root Canals, ( ) Dentures, (X) Other Exam
Patient Initials _____

2. DRUGS AND MEDICATION: I understand that antibiotics, analgesics and other medications may cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of any and all medications I am currently taking., including but not limited to prescriptions medications, over-the-counter medications, herbal remedies, and alternative medications. I further understand that failure to advise my dentist of any medications I am taking prior to starting dental work may have unforeseen negative consequences for me.
Patient Initials _____

3. CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.
Patient Initials _____

4. REMOVAL OF TEETH: Alternatives to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc), and authorize the dentist to remove the following teeth: _____, and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved with extractions, some of which are pain, swelling, spread of infection, dry socket, and loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time, and fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.
Patient Initials _____

5. CROWNS, BRIDGES AND CAPS: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridge, or cap (including shape, fit and color) will occur only before final cementation. It is also my responsibility to return for permanent cementation within 21 days from initial tooth preparation. Excessive delays may allow for tooth movement which may necessitate a remake of the crown, bridge or cap. In such instances, I understand that there will be additional charges for remakes due to my delaying permanent cementation.
Patient Initials _____

2220 Coit Rd., Ste. 570
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Ph: 972-964-6500
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6. ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may-extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

Patient Initials _____

7. PERIODONTAL LOSS (TISSUE AND BONE): I understand that if I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss and that it can ultimately lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that any dental procedure may have future adverse effect on my periodontal condition.

Patient Initials _____

8. Fillings: I understand that care must be taken when chewing on fillings specially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that increased sensitivity is a common effect of a newly placed filling.

Patient Initials _____

9. DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in in eating are common problems associated with dentures. Immediate dentures (placement of denture immediately after extractions) may be painful. In addition, immediate dentures often require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of 30 days or more, there may be additional charges assessed against me.

Patient Initials _____

I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized. I hereby authorized any of the doctors or dental assistants or auxiliaries to proceed with and perform the dental restorations and treatments indicated above and as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that my arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

Signature of Patient: _____ **Date:** _____

Signature of Patient Guardian: _____ **Date:** _____

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 provide safeguards to protect your privacy. These Safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal to providing you with quality service and care. For this reason, our practice has adopted the following polices:

1. Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the rules of confidentiality.

4. The patient understands and agrees to inspections of the office and review of documents which may include PHI by government agencies or insurance companies through the normal performance of their duties.

5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

6. Your confidential information will not be used for purposes of advertising or marketing of products, goods, or services. Such prohibition does not include treatment/product samples or goods of normal value.

7. The practice agrees to provide the patient with access to their records in accordance with state law.

8. The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

I, _____, do hereby agree to the terms set forth above and any subsequent changes in the office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

_____ _____

Patient or Guardian Signature: Date:

DENTAL PLACE OF PLANO

2220 Coit Rd., Suite 570, Plano, TX 75075 P: 972-964-6500 F: 972-964-6511

Over 18 HIPAA Release and Authorization Form

Dental Place of Plano will not release dental information to anyone without my written authorization in accordance with this document.

____ **I DO NOT** grant any access to anyone**. No dental information, records or appointment status information can be discussed or released.**

_____ **I WISH TO** grant access to the following listed individual to my dental care providers and/or dental information as follows:

_____
(Print Name; indicate his/her relationship to you.)

_____
(Print Name; indicate his/her relationship to you.)

I give the above-named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any provider or staff member to discuss my dental care, and access my complete dental records and they may receive contact by phone, email, mail and any other means for appointment communication. **THEY HAVE NO RESTRICTIONS. (Initials)** _____

_____ _____
PATIENT PRINTED NAME DOB

_____ _____ _____
PATIENT SIGNATURE DATE PATIENT CONTACT NUMBER

I acknowledge that I have received the Notice of Privacy Practices _____ (Initials)

This authorization is valid indefinitely from the date signed unless Dental Place of Plano is notified otherwise. I understand that I can withdraw consent at any time by providing Dental Place of Plano with written notice indicating the changes in access. I understand that authorizing this disclosure of this dental information is voluntary. I need not sign this form to assure dental care or treatment. I understand that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.

FINANCIAL AGREEMENT

For the purposes of this document, the "dental practice" is _Dental Place Of Plano__

Our goal is that our patients understand their treatment needs, as well as its exclusive financial responsibility before starting treatment. It is our desire to make affordable dental care to all our patients. Please review the following policies and procedures:

PAYMENT POLICY: Payment is due at the time of the service. If you have dental insurance, your estimated co-payment plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit.
1. We accept cash, personal checks with proper identification, money orders, debit cards, Visa, MasterCard, Discover, American Express
2. If there is a balance and charges have been in the account for more than 90 days, you will have to pay the Dental Practice 18% finance charge per month on the outstanding balance until it is paid in full.
3. You will be responsible for any and all expenses incurred in the collection of the debt (i.e., collection costs, court fees and/or attorney fees)
4. Financing is available through Care Credit and Compassionate Care with prior approval.
5. A fee of $ 35 if applicable for any check returned by the bank.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:
1. You must provide us with an insurance card and/or all information necessary to verify your coverage and file your claim.
2. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you; not with your insurance company.
3. You are responsible for paying our fees; not what your insurance company allows or considers "usual, customary and reasonable" (UCR), all of which vary from one company to another.
4. Although we can estimate your insurance benefits we are not responsible for their accuracy. Knowing the amount of your benefits, limitations, exclusions, waiting periods, etc. is entirely your own responsibility. Receiving our services implies the acceptance of responsibility to pay regardless of our estimate.
5. 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 vary from one company to another. Rates for non-covered services, plus deductibles and co-payments are due at the time of treatment.
6. Treatment provided in another dental office during the current plan year may alter your co-payments due for services in our office. In such cases we are not able to track whether or not you have reached your yearly maximum. Please call your insurance company if this applies to you.
7. There are many factors in determining patient responsibility in case of coordination of benefits between two insurance companies. We will provide you the most accurate information available to us, but we cannot guarantee what your out of pocket benefit will be.
8. Please understand that our responsibility is to provide treatment that best suits your needs, not to try to match your care to insurance plan limitations.

CANCELLED OR MISSED APPOINTMENTS: To cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of up to $ 50.00 (fee based on consultation length and/or the number of missed appointments). Missed or cancelled appointments prevent others from receiving the dental care they deserve.

1. We reserve the right to terminate or suspend professional treatment of any patient when scheduled appointments are not kept.

I have read and understood this document in its entirety; outlining the office and financial policies of the dental practice and agree to these terms.

Patient Name / guardian _____

Signature of Patient / guardian_____ Date: _____

DENTAL PLACE OF PLANO
2220 Coit Rd., Suite 570, Plano, TX 75075 | Ph: 972-964-9500 | Fax: 972-964-6511 | www.dentalplaceofplano.com

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Dr. _____, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

☐ Check here if you do not want your full face shot used for any of the above purposes

Signature (Patient)_____

Date_____

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT

NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non-essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are “potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection.” The ADA also recommends that urgent dental care which “focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments” be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

Signature Date

_____

Witness

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	**No**
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____

Witness