

Patient's Confidentiality Instructions

Patient Name _____

It is important for us to honor your confidentiality. Please check your preferences below.

_____ You may discuss my dental/account information **only** to me

_____ I give my permission to discuss dental account with the following people:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

Yes Or No You may leave a message with details on my voicemail at:
(Circle one)

Cell# _____

Home# _____

Work # _____

Patient/Responsibility Signature

Date

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

Please Print Name

Signature

Date