STOCKTON FAMILY & COSMETIC DENTISTRY

You may refuse to sign this acknowledgement & authorization, in refusing we may not be allowed to process your insurance claim.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor / facilities in the future.

_____ _____

Please *print* name of patient *Signature* of patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

How do you want to be addressed when summoned from the reception area:

☐ First Name Only ☐ Proper Sir Name ☐ Either ☐ Other _____

Please list any other parties who can have access to your dental information:
(This includes spouse, stepparents, grandparents, children and any care takers who can have access to this patient's records)

☐ Not Applicable

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to confirm my appointments, treatment & billing information, and information about my health via:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation

I approve being contacted about special services, events, fund raising efforts and new health info on behalf of Stockton Family Dentistry via:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation

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