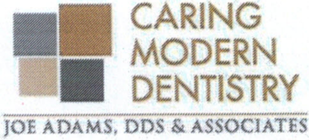

Patient Name: ____

Current Address: ____

City: ______________________________ Zip: ______________

Home Phone #: ____________________________ Work Phone #: ____________________________

Email Address: ____

Cell Phone #: ______________________________ Can we send texts about appointments? Y or N

Preferred Contact Method: ______________________________________

♦ At your preferred contact method above, can we leave detailed appointment reminders? Y or N

☐ For email and/or text communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected above.

Have there been any changes in your dental insurance information? Y or N
(if yes, please provide front desk with you dental insurance card/information)

♦ Who may we discuss your treatment needs with? ____

Relationship: ____________________________________ Best Number: ______________________________

♦ Who may we discuss your account information with? ____

Relationship: ____________________________________ Best Number: ______________________________

Patient Rights: I have the right to revoke this authorization at any time. I may inspect or copy the protected health information to be disclosed as described on this paper. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY THE PATIENT.

____ ______________________

Signature of Patient or legal guardian is patient is under 18. Date