Paoli Family Dentistry

Patient Name:_____ Date of Birth_____

Home_____ Cell_____ Work_____

Please circle the number that is your preferred contact number

COMMUNICATION PERMISSION

To preserve your privacy, we would like you to indicate how to communicate information to you. Without your permission, we will not release any of your medical or billing information to another person.

Please check:

_____ I give permission for Paoli Family Dentistry personnel to leave appointment confirmation and medical information on an answering machine.

_____ I give my permission for Paoli Family Dentistry personnel to mail any information pertaining to my care to the address I have provided.

_____ I give permission for Paoli Family Dentistry to leave or discuss any **medical information** pertaining to me to the individual(s) listed below:

_____ I give permission for Paoli Family Dentistry personnel to leave or discuss any **billing or insurance information** to the individuals listed below:

Name:_____ Relationship_____ Phone#_____

Name:_____ Relationship_____ Phone#_____

Name:_____ Relationship_____ Phone#_____

_____ I give permission for Paoli Family Dentistry personnel to email information pertaining to my care to the following email:_____

_____ I give permission for Paoli Family Dentistry personnel to text appointment information to my cell phone. (*Text messaging rates may apply*)

I assume responsibility to inform the practice of any changes in regards to the above items.

Patient Signature:_____ Date: _____