FAMILY DENTISTREE OF SARASOTA, INC.

Keeping Your Personal Health Information Private

_____

(Last Name) (First Name) (M.I.)

Do we have your permission to:

Send an appointment reminder card to your home? Y____N____

Leave the following information on your home or cellular answering machine/voice mail:

Appointment information Y_____N_____ Billing Information Y_____N_____
Medical Information Y_____N_____

Leave medical information on your work answering machine/voice mail:

Appointment information Y_____N_____ Billing Information Y_____N_____
Medical Information Y_____N_____

I agree that the dental practice may communicate with me electronically at this email address: _____

(I am aware that there is some level of risk that third parties might be able to read unencrypted emails.)

I give permission to share appointment and/or billing information with the person named below:

Name: _____

I give permission to share medical information with the person named below:

Name: _____

If any of the above information changes, it is the Patient/Parent/Legal Guardian's responsibility to contact our office.

Patient/Parent/Legal Guardian Signature _____ Date _____