PATRIOTS PARK DENTAL
General • Restorative • Cosmetic

Notice of Privacy Policies (HIPAA)

Patient Name: _____ DOB _____

1. Please list the family member(s) or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

2. Please list family member(s) or other person(s), if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY. If same as person(s) listed above, check here: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

3. Please print the address of where you would like any mailed correspondence from our office to be sent.

   _____

4. Please print the telephone number(s)where you want to receive calls about your appointments or other health care information.

   _____

5. Will you allow confidential messages to be left on your telephone answering machine or voicemail?

   Yes _____ No _____

6. I am fully aware my health information will/may be transmitted by electronic transmission, secure fax transmittal, internet, or email for my continued health care needs.

I am aware of the HIPAA policies and practices for Patriots Park Dental. I will be provided a copy of the Notice of Privacy Practices on Patriots Park Dental's website or in the office if requested. I understand I am giving permission to Patriots Park Dental and any health care professional/office, laboratory, pharmacy or other covered health care provider to include dental insurance companies regarding my dental services/conditions past, present, or future. I understand the authority given has no expiration. I also understand I have the right to revoke permission in writing and delivered to Patriots Park Dental.

_____ _____

Signature Date

Updated 3/2/23