Pink Oral Surgery & Dental Implants

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I have been given the opportunity to review the Notice of Privacy Practices (via the practice website WWW.PINKORALSURGERY.COM or in-office) Pink Oral Surgery & Dental Implants. I understand the terms stated herein are to remain in effect throughout my treatment with: Pink Oral Surgery & Dental Implants.

The following people are authorized to speak on behalf of my account and/or treatment plan:

Name: _____Relation: _____ Phone#:_____

May we speak with them regarding: ( ) Account ( ) Treatment Plan (Check each box that applies)

Name: _____ Relation: _____ Phone#:_____

May we speak with them regarding: ( ) Account ( ) Treatment Plan (Check each box that applies)

Name: _____ Relation: _____ Phone#:_____

May we speak with them regarding: ( ) Account ( ) Treatment Plan (Check each box that applies)

Messages with confidential information may be left at: (please complete)

( ) Cell Phone: _____ ( ) Home Phone/Other: _____

( ) Work Phone: _____ ( ) E-mail: _____

Patient/Guardian Signature:_____ Date:_____

Print Name:_____

Staff Signature: _____ Date: _____

Revised 2023