OAKTON FAMILY DENTISTRY

PLEASE COMPLETE ALL THREE BOXES

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I have received a copy of Oakton Family Dentistry Notice of Privacy Practices.

_____

Print Name of Patient or Personal Representative **DATE**

_____

Signature of Patient or Personal Representative

I authorize that I am Personal Representative for the following additional person(s):

_____ _____

Please Print Name **Please Print Name**

ACKNOWLEDGEMENT OF TRANSMISSION OF RECORDS

I give my consent to receive communications electronically from Oakton Family Dentistry. I give permission for x-rays and dental records to be forwarded electronically to other dental offices or insurance companies should they be requested.

_____

Print Name of Patient or Personal Representative **DATE**

_____

Signature of Patient or Personal Representative

I authorize that I am Personal Representative for the following additional person(s):

_____ _____

Please Print Name **Please Print Name**

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I have received a copy of Oakton Family Dentistry Office Financial Policies.

_____

Print Name of Patient or Personal Representative **DATE**

_____

Signature of Patient or Personal Representative

As personal representative, I authorize to accept financial responsibility for the following additional person(s):

_____ _____

Please Print Name **Please Print Name**