ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Krupa's Notice of Privacy Practices

Patient Name (Printed): ___________________________________

Patient Signature: ____ Date: ______________

PATIENT COMMUNICATION PERMISSION

As a patient in our office, from time to time we may need to communicate with you when you are not available. To preserve your privacy, we would like for you to indicate your preferred method for us to communicate dental information to you. Without specific permission we will not release any of your dental information to another person. In some cases you may wish for another person to have access to our dental information. Please list any person you wish to have access to this information.

NAME & PHONE #: RELATIONSHIP:

____________________________________ __________________________

____________________________________ __________________________

In the event that no one is available to answer your phone, we need your permission to leave certain types of dental information on your answering machine or voicemail.

_____ Do not leave any information on answering machine or voicemail

_____ I give my permission to leave the following information pertaining to me on my answering machine or voicemail at the following number(s) listed below.

Home Phone#: _______________ Cell Phone #: ________________Work #: ______________

Appointment reminders: _____ YES _____ NO

Any other type of dental communication: _____ YES _____ NO

I assume responsibility to inform this office of changes in my phone number or my preferences.

Signature: ____________________________________

Date:_______________