LONGS PEAK DENTISTRY

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PATIENT NAME:_______________________________

PATIENT'S PRIVACY INFORMATION

THIS FORM IS FOR ANYONE OVER THE AGE OF 18 YEARS OLD

Please list the family member or other persons, if any, we may inform about your general medical condition and your diagnosis, including appointments for treatment, payment information and healthcare operations:

Name________________________________Relationship_______________Phone________________

Name________________________________Relationship_______________Phone________________

Name________________________________Relationship_______________Phone________________

Name________________________________Relationship_______________Phone________________

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Or-Only in an emergency: Please list the family members or other persons whom we may inform about your medical condition.

Name________________________________Relationship_______________Phone________________

Name________________________________Relationship_______________Phone________________

Name________________________________Relationship_______________Phone________________

Name________________________________Relationship_______________Phone________________

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Patient/Guardian Signature_______________________________________Date_________________