Dorothy Pasikowski D.D.S., P.C.

Cosmetic & General Dentistry

Patient Name:_____ Date: _____

- I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for Dr. Dorothy Pasikowski D.D.S., P.C.
- I may refuse to sign
- I understand that I may request a copy of the privacy policies at any time.
- I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party.

Please list any other parties who can have access to your dental information

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____Phone #: _____

I Authorize Contact from This Office to Confirm My Dental Appointments, Treatment, & Billing Information and Information About My Dental Health Via:

Message On:

- ☐ Home Phone _____
- ☐ Cell phone _____
- ☐ Work phone _____
- ☐ Text _____
- ☐ Email _____
- ☐ Any of the Above

_____ _____ _____

Print Name Sign Name Date