PEARL DENTAL

HEALTH INFORMATION

DISCLOSURE AGREEMENT

I, _____

do hererby grant permission for Pearl Dental to disclose my personal health information to the following personal representatives: (spouse, sibling, parent, child, friend, etc.)

_____

_____

_____

INFORMATION TO BE DISCLOSED

[ ] Appointment dates and time
[ ] Treatment plans and referrals
[ ] Financial and billing information
[ ] Any other pertinent dental health information related to treatment at this office.
[ ] None of the above

CAN WE LEAVE A DETAILED MESSAGE ON YOUR VOICEMAIL OR ANSWERING MACHINE?

[ ] Yes [ ] No

PHONE NUMBER TO USE FOR THAT DETAILED MESSAGE

_____

FOR DEPENDENTS AGES 18-26, SOME INSURANCE COVERAGE DEPENDS ON YOUR STUDENT STATUS. PLEASE HELP US TO KEEP YOUR SCHOOL INFORMATION CURRENT.

SCHOOL ATTENDING

_____

ARE YOU A FULL TIME STUDENT?

_____

SCHOOL CITY AND STATE

_____

I UNDERSTAND THAT THIS PERMISSION WILL REMAIN IN EFFECT UNLESS A WRITTEN CANCELLATION HAS BEEN PROVIDED TO PEARL DENTAL.

PATIENT SIGNATURE:

_____

DATE OF BIRTH: **DATE:**

_____

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Sauk Rapids, MN 56379

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