

Confidential Information Agreement

Please list the family members or other persons, if any, with whom we may discuss your dental treatment and/or your diagnosis:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Please list the family members or other persons, if any, with whom we may discuss your dental treatment **ONLY IN AN EMERGENCY**.

_____ Same as above

_____ No one

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Please print the telephone number, if any, where you want to receive calls about appointments, billing and insurance inquiries, or dental healthcare questions.

Telephone Number _____

May confidential messages be left on the answering machine or voicemail number given above? Yes _____ No _____

If you do not have an answering machine or voicemail, may a confidential message be left with a secretary or personal assistant? Yes _____ No _____

I understand that this agreement remains in effect until revoked by me in writing. If I revoke my consent, such revocation will not affect any actions that Dr. Vicki Borowski took before receiving my revocation.

Patient's Signature

Date

Witness

Date