BOISE ENDODONTICS

Patient Name: _____

Date of Birth: _____

PROTECTED HEALTH INFORMATION PATIENT/FAMILY COMMUNICATION

☐ You have my permission to talk with my spouse, family, friend, and/or legal representative involved in my medical care who are listed below.

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Is it okay for Boise Endodontics to leave a message for you regarding your treatment?

☐Yes ☐ No

If yes, let us know how we may do that.

☐ Home phone _____ ☐ Cell Phone_____

☐I acknowledge that I have received the Notice of Privacy Practices from Boise Endodontics.

_____ _____ _____
Patient Signature Date Time

_____ _____ _____
Parent or Guardian (if under 18 or unable to sign) Date Time

_____ _____ _____
Interpreted by (if applicable) Date Time