

GO SMILES

PLEASE COMPLETE ALL THREE BOXES

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I have received a copy of Go Smiles Notice of Privacy Practices.

Print Name of Patient or Personal Representative

DATE

Signature of Patient or Personal Representative

I authorize that I am Personal Representative for the following additional person(s):

Please Print Name

Please Print Name

ACKNOWLEDGEMENT OF TRANSMISSION OF RECORDS

I give my consent to receive communications electronically from Go Smiles. I give permission for x-rays and dental records to be forwarded electronically to other dental offices or insurance companies should they be requested.

Print Name of Patient or Personal Representative

DATE

Signature of Patient or Personal Representative

I authorize that I am Personal Representative for the following additional person(s):

Please Print Name

Please Print Name

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I have received a copy of Go Smiles Office Financial Policies.

Print Name of Patient or Personal Representative

DATE

Signature of Patient or Personal Representative

As personal representative, I authorize to accept financial responsibility for the following additional person(s):

Please Print Name

Please Print Name