HOCKESSIN DENTAL
FAMILY & COSMETIC DENTISTRY

**Patient Request for Confidential Communications**

To the Patient: Use this form if you would like our dental practice to communicate with you other than your primary phone number, email addresses and/or mailing addresses. Fill out this request in its entirety.

**Patient Name (print):** _____

Alternative communication request (please tell us the way you would like us to communicate with you, and/or the address you would like us the use if different from your patient registration information):

_____

_____

Please indicate any family members/3rd parties that your health information may be shared if needed:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**Payment Information:**

Your request may affect our normal billing and payment procedure. Please specify your alternative method for handling payment. Typically payment is due at the time of treatment and any invoices or statements would b sent to your provided address and/or email address.

_____

_____

**Signature of Patient:** _____ **Date:** _____

**For Personal Representatives of the Patient**

Print Name: _____

Relationship to the patient: _____ Date: _____