RON WILSON DDS INC.

Serving Families Since 1999

Patient Name:_____

Date:_____

PATIENT ACKNOWLEDGEMENT OF HEALTH INFORMATION PRIVACY ACT

I acknowledge that I have been given an opportunity to review the Notice Of Privacy Practices by Ron Wilson, DDS, Inc. and will be provided a copy if I desire one.

In order to assist us in protecting your privacy, please fill out the following, **COMPLETELY.**

List all contact numbers **(circle preferred # for appointment reminders):**

Home:_____Cell:_____Work:_____

____**YES** ____**NO** You **may** leave a detailed **message** on the **preferred numbers** listed above

____**YES** ____**NO** You **may** leave **messages** and **discuss my care** (including Test Results, Services, Billing inquires) with the following:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

_____ _____

Signature of Patient (or Legal Guardian) **Date**

_____

Patient's Name (or Legal Guardian) *Please Print*

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