HEALTHY POINTE DENTAL, PC
18100 Mack Avenue
Grosse Pointe, MI 48230

Patient Acknowledgement

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____ _____
Patient/Legal Guardian Signature | Patient/Legal Guardian Name (please print) | Date

Children's Name(s) (under 18 years of age)

_____ _____ _____

For office use only
Patient Refused to Sign
The following circumstances prohibited the patient from signing the Acknowledgment:
_____
An emergency situation prevented the patient from signing the Acknowledgment.

_____ _____ _____
Office Personnel (signature) | Office Personnel (print name) | Date

I agree that the dental practice, Healthy Pointe Dental PC, may communicate with me:

- ☐ electronically at the email address below
- ☐ via text message at the phone number below

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice with any updates to my email address or phone number.

I can withdraw my consent to electronic communications by calling: (313) 884-6680

Email address: _____@_____

Phone Number: _____

_____ _____
Patient/Legal Guardian Signature | Date

_____
Patient/Legal Guardian Name (printed)

TURN OVER

HEALTHY POINTE DENTAL, PC
18100 Mack Avenue
Grosse Pointe, MI 48230

Consent to Release Information

I, _____, authorize Healthy Pointe Dental PC to share billing, financial information, dental and medical history, conditions, findings, radiographs, recommended treatment, and any other pertinent information as it relates to my dental treatment with the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

*You have the right to terminate this authorization at any time by submitting a written request to our office manager.

May we leave messages on your answering machine/voicemail? Yes_____ No_____

HIPAA requires permission to leave messages on an answering machine/voicemail.

Please list an emergency contact who is authorized to receive any pertinent information regarding your dental health as requested by a staff member or dentist of Healthy Pointe Dental PC.

Name: _____

Home Phone:_____ Cell Phone: _____

Address: _____

_____ _____

Signature of Patient/Legal Guardian Date

_____

Name of Patient/Legal Guardian (Printed)