Patient Acknowledgement of Notice of Privacy Practices

BRENTWOOD DENTAL SPECIALISTS, LLC
ALEXANDRA HENDRICKS, D.M.D.

Patient Name: _____ **DOB:** _____

Patient Name: _____ **DOB:** _____

Patient Name: _____ **DOB:** _____

Patient Name: _____ **DOB:** _____

Patient Name: _____ **DOB:** _____

Patient/Guardian Printed: _____

Please list any and/or all person(s) that can receive information about the patient(s) listed above:

_____ _____

_____ _____

Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would appreciate very much your acknowledging that you have read and agree to our Notice of Privacy Practices by signing below.

Patient or Patient Guardian Signature: _____

Date: _____