Coweta Smiles
Mark Harwood D.D.S.

Patient Name: _____ Date: _____

- I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for Coweta Smiles Dental.
- I may refuse to sign.
- Expiration: 3 years from initial/last signature; insurance change; patient reaches age of 18.
- I understand that I may request a copy of the privacy policies at any time.
- I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION AND INFORMATION ABOUT MY DENTAL HEALTH VIA:

- ☐ Home phone
- ☐ Cellphone
- ☐ Work phone
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ Any of the above

_____ _____

Please print your name Please sign your name

- ☐ Patient
- ☐ Parent
- ☐ Guardian
- ☐ Other: _____