

City Square Dental Care
**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES**

You may Refuse to Sign This Acknowledgement

I, _____, have received a copy of this
office's **Notice of Privacy Practices**.

Signature

Date

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____
Please print

Date of Birth: _____

Please provide the address and phone number you prefer us to use when contacting you:

Address: _____

Phone #(s): _____

May we leave a message at either number: YES _____ NO _____

EMAIL: _____

**If the address provided above is not your home address OR is not a street address,
please provide us with a street address for purposes of ensuring payment:

Patient Signature

Date