Hero Pediatric Dentistry

PLEASE COMPLETE ALL THREE BOXES

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I have received a copy of Hero Pediatric Dentistry Notice of Privacy Practices.

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Print Name of Patient or Personal Representative DATE

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Signature of Patient or Personal Representative

I authorize that I am Personal Representative for the following additional person(s):

__________________________________ __________________________________

Please Print Name Please Print Name

ACKNOWLEDGEMENT OF TRANSMISSION OF RECORDS

I give my consent to receive communications electronically from Hero Pediatric Dentistry. I give permission for x-rays and dental records to be forwarded electronically to other dental offices or insurance companies should they be requested.

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Print Name of Patient or Personal Representative DATE

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Signature of Patient or Personal Representative

I authorize that I am Personal Representative for the following additional person(s):

__________________________________ __________________________________

Please Print Name Please Print Name

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I have received a copy of Hero Pediatric Dentistry Office Financial Policies.

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Print Name of Patient or Personal Representative DATE

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Signature of Patient or Personal Representative

As personal representative, I authorize to accept financial responsibility for the following additional person(s):

___________________________________ ____________________________

Please Print Name Please Print Name