CALEDONIA
FAMILY DENTISTRY

Date: _____

Previous Dentist Information

Name: _____

Address: _____

_____

_____

Please send a copy of the most recent radiographs and records to our office.

Thank you for your timely response.

EMAIL: staff@caledoniafamilydentistry.com

Address: 3352 Brown Rd. Caledonia, NY 14423

Phone: 585-538-4500 Fax: 585-538-9565

Patient Name: _____ Date of Birth: _____

Address: _____

_____

_____

Parent/Guardian Signature: _____ Date:_____

Thank you,

Caledonia Family Dentistry

CALEDONIA
FAMILY DENTISTRY

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers (dental insurance)
- Conduct normal healthcare operations such as send appointment reminders, make reminder phone calls and scheduling appointments

I acknowledge that I have the right to receive your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

(Please Print)

Relationship to patient (if minor): _____

Signature: _____

Date: _____

If you would like other family members to have access to your dental information, please include their names below:

_____ (Relationship to Patient): _____

_____ (Relationship to Patient): _____

_____ (Relationship to Patient): _____