

Berkers Family Dentistry S.C.

Finance charge of 1% per month (12% annum) applied to accounts over 90 days.

Name _____

- 1. I acknowledge receipt of the Privacy Practice Notice
- 2. The use of my dental records will be used only to carry out treatment, and healthcare operations, such as submission of insurance claims and referrals to specialists.
- 3. I understand that the information that I have given today is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status.
- 4. The following people may inquire or have access to my dental records for disaster relief purposes as permitted by law.

(name of person)

(name of person)

Signature of patient, parent, or guardian

Date

IN OFFICE USE ONLY

I have read my medical history and confirmed:

___ no changes ___ changes _____

Signature _____ Date _____

I have read my medical history and confirmed:

___ no changes ___ changes _____

Signature _____ Date _____