Eden Baluyot Vincent, D.M.D., LLC

508 Pleasant Valley Way
West Orange, NJ 07052
Tel. (973) 731-0087 Fax (973) 731-0024

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices

_____ Date:_____/_____/_____
Patient or Guardian Signature

Privacy Information

Please check and circle all that apply

_____ The office may *leave voice messages* at my HOME / WORK/ CELL phone ***regarding my appointments***.
_____ The office may *leave text messages* at my CELL phone ***regarding my appointments***.
_____ I prefer the office **not** to leave any messages at any phone numbers provided regarding my appointments.

_____ The office may leave voice messages at my HOME/ WORK/ CELL phone ***regarding my balances and payments***.
_____ I prefer the office **not** to leave any messages at any phone numbers provided regarding my payments

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I give permission for Dr. Vincent to discuss my dental health and treatment with:

	Name(s)	Phone Number
_____ Myself Only	_____	(_____) _____-_____
_____ Spouse	_____	(_____) _____-_____
_____ Parents	_____	(_____) _____-_____
_____ Children	_____	(_____) _____-_____
_____ Others (please specify relationship):	_____	(_____) _____-_____

I give permission for Dr. Vincent/ Office to discuss my financial matters (ins. payments, co-pays, balances, etc.) with:

(Please also check the person who is listed as the Responsible Party or Insurance Subscriber of your policy as the above matters will need to be discussed)

	Name(s)	
_____ Myself Only	_____	(_____) _____-_____
_____ Spouse	_____	(_____) _____-_____
_____ Parents	_____	(_____) _____-_____
_____ Children	_____	(_____) _____-_____
_____ Others (please specify relationship:	_____	(_____) _____-_____

_____ Date:_____/_____/_____
Patient or Guardian Signature