DISCLOSURE ACKNOWLEDGEMENT AND CONSENT FORM

SELECTIVE DENTAL
3151 S. WHITE RD., SUITE 203
SAN JOSE, CA 95148
Office: 1-408-238-7646 Fax: 1-408-238-8096
Email: contact@selectivedentalsanjose.com

Patient Name: ____ Date of Birth: ____/____/______

I wish to be contacted in the following manner (check all that apply):

Home or mobile number: __________________________________

☐ Leave message with detailed information
☐ Leave message with call-back number ONLY – NOT detailed information

Written Communication

☐ Mail to my home address
☐ Mail to my work/office address
☐ Email to this address: __________________________

Work telephone number: ___________________________________

☐ Leave message with detailed information
☐ Leave message with call-back number ONLY – NOT detailed information

Also, I acknowledge and consent for Dr. Victoria Vuong/staff to disclose and discuss personal health information with/and to the following individual:

Name: ______________________________________ Relationship: ______________________________

Date of Birth: ____/____/______ Phone Number: _____________________________

Name: ______________________________________ Relationship: ______________________________

Date of Birth: ____/____/______ Phone Number: _____________________________

In the event that I wish to rescind this, I will write and notify Dr. Victoria Vuong/Staff.

Signed: ____ Date: ______________________________
Patient or Legal Authorized Representative

Name: ____ Relationship: ________________________
If Signed on Behalf of the Patient

Thank you for choosing our office!