

# Gary Vander Vliet, DMD, MAGD

## HIPAA Confidential Communication Agreement

Patient Name \_\_\_\_\_

Please list the family members or other persons (if any), with whom we may contact to discuss your dental treatment and/or your diagnosis, confirm or discuss appointments, or in case of an emergency.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Print the telephone number where you want to receive calls about appointments, billing and insurance inquiries, or dental healthcare questions:

Telephone Number: \_\_\_\_\_ Text: Yes \_\_\_\_\_ No \_\_\_\_\_  
Voicemail: Yes \_\_\_\_\_ No \_\_\_\_\_

Alternate Number: \_\_\_\_\_ Text: Yes \_\_\_\_\_ No \_\_\_\_\_  
Voicemail: Yes \_\_\_\_\_ No \_\_\_\_\_

Email: \_\_\_\_\_

Print Name \_\_\_\_\_

Signature \_\_\_\_\_