Crystal Springs Dental
Patient Confidentiality Questionnaire

Patient Name:_____

*****Should the need arise, I authorize Crystal Springs Dental to share with the following people (ie. spouse, family member, friend) information about my dental condition (including treatment, payment and health care operations)**
Name:_____**Relationship:**_____
Phone:_____
Name:_____**Relationship:**_____
Phone:_____

***In case of an emergency and if all other persons listed above are not available, Crystal Springs Dental may contact:**
Name:_____**Relationship:**_____
Phone:_____
Name:_____**Relationship:**_____
Phone:_____

***I would like all correspondence and/or patient balance statements sent to:**
HOME ADDRESS
Or
OTHER:_____

I would like to receive calls about my appointments, lab and x-ray results or other private healthcare information at:
HOME PHONE
Or
OTHER: (Area Code)_____

***Can confidential messages (ie., appointment reminders, premed. Reminders, etc.) be left on your telephone answering machine/voicemail at home or work?**
☐ **YES / NO** ☐

PRINT NAME:_____**DATE:**_____
SIGNATURE:_____