

**Downtown Dental Studio
160 Broadway Suite 509
New York, NY 10038
(212) 964-3337**

PATIENT CONFIDENTIALITY

In this office, **Patient Confidentiality** is a prime concern. Please indicate below with whom our office can or cannot leave a message. Please check where appropriate.

	YES	NO	DOESN'T APPLY
Spouse	___	___	___
Children	___	___	___
Answering Machine Home	___	___	___
Answering Machine Work	___	___	___

Are you able to receive calls at your workplace? _____

May we call you at your workplace and state who is calling? _____

Due to our confidentiality regulations, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.

Please check with whom we may discuss your situation.

	YES	NO	DOESN'T APPLY
Spouse	___	___	___
Children	___	___	___

Children and/or Significant Others

Name _____

Relationship _____

Phone _____

Name _____

Relationship _____

Phone _____

Signature

Date