

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that a copy of The Oaks Dental Group’s Notice of Privacy Practices was available for me to view upon request.

Patient Name: _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: Home: _____ **Work:** _____ **Cell:** _____

Social Security: _____

Pharmacy Name AND Phone Number: _____

****WE ARE NOW USING A SYSTEM THAT USES TEXT AND EMAIL REMINDERS. A VALID EMAIL ADDRESS WILL ALSO GIVE THE ABILITY TO REVIEW YOUR ACCOUNT ONLINE AS WELL AS MAKE PAYMENTS****

Please CHOOSE Your Preferred Method of Contact:

Call Number: _____

Email Address: _____

Text Number: _____

Insurance Information:

Name of Insurance Holder, Address and Telephone Number:

Insurance Holder’s Date of Birth And Social Security Number:

Name of Employer Providing Insurance:

Name of Insurance Company:

Signature: _____ **Date:** _____