



## Hillcrest Dental Care

Patient Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

In order to assist us in keeping your information private please list any family, friends or caregivers that you would like to be involved in your care. By listing someone on this form you are authorizing Hillcrest Dental Care employees to discuss your treatment with them.

Name	Relationship	Date of Birth (for verification only)	Phone Number

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

This information remains in effect unless terminated in writing by the patient.

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