

# Denise T. Nguyen, DDS, PC

herein after referred to as "Provider"

## **Patient's General and Emergency Contact Information Sheet**

Please complete this form by indicating a check mark in each section that would be an acceptable manner in which our practice can contact you.

- In case of an emergency I authorize Provider to contact \_\_\_\_\_  
at (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_. My relationship to this contact is: \_\_\_\_\_

I wish to be contacted by Provider in the following manner (please check all areas that would be an acceptable manner for Provider can contact you):

- Please contact me on my home telephone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
 Provider can leave their name and phone number only when they call.  
 Provider can leave a detailed message when they call.
- Please contact me on my cellular phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
 Provider can leave their name and phone number only when they call.  
 Provider can leave a detailed message when they call.
- Please contact me at work: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
 Provider can leave their name and phone number only when they call.  
 Provider can leave a detailed message when they call.
- Provider can mail or email me information such as appointment reminders, and future clinical sponsored programs.  
 Provider can mail information to my home address.  
 Provider can mail information to my work address.  
 Provider cannot mail information to my home or work address, except statements of my account.  
 Provider may send me email messages such as appointment reminders at the following email address: \_\_\_\_\_. (Leave blank if you do not wish to be contacted via email.)
- I hereby give permission to Provider, to release medical information pertinent only to my current medical condition to: \_\_\_\_\_ relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date