

Heights Dental Smiles
Susanna N. Zilberman, D.D.S.

PATIENT INFORMATION RELEASE CONSENT

List the family members or others, if any, relationship, and contact numbers, with whom we may discuss your general dental conditions and diagnosis:

List the family members or others, if any, relationship, and contact numbers, whom we may contact in case of an emergency:

List the family members or others, if any, relationship, and contact numbers, with whom we may discuss your billing information, including account balance:

List Pharmacy name and contact number where we may call in and discuss prescriptions and medication interactions with pharmacist:

You may leave messages (i.e. appointment reminders):

With others at my home:	Yes	No
On my answering machine at home:	Yes	No
With others at my work:	Yes	No
On my voice mail at work:	Yes	No
On my cell phone:	Yes	No

I authorize the use of x-rays, study models, photographs and/or videotapes of my case for presentations and publications of the doctor.

Signature of Patient/Guardian _____

Please print name _____ Date _____