Baker
DENTAL STUDIO

Nithya Baker, D.D.S
2060 East Paris Ave. SE
Suite 210
Grand Rapids, MI 49546
P: 616.949.7290
F: 616.949.6108
front@bakerdentalstudio.com

HIPAA OMNIBUS RULE

What is your preferred name when called from the reception area?

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I authorize contact from East Paris Dental Professionals to confirm my appointments, treatment, and billing information via:

☐ Cell phone ☐ Text message ☐ Home phone
☐ Email ☐ Work Phone ☐ Any of the above

I authorize information about my health to be conveyed via:

☐ Cell phone ☐ Text message ☐ Home phone
☐ Email ☐ Work Phone ☐ Any of the above

Please list any other parties who are actively involved in your health care and who may have access to your health/billing information: (This includes parents (if over 18), step parents, grandparents, siblings, caretakers, or any others who may have access to this patient's **record):**

Name:_________________________________ Relationship________________________

Name:_________________________________ Relationship:_______________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Baker Dental Studio. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

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Printed Name of Patient

____________________________________ **Date:** ________________
Signature of Patient/Parent/Guardian/ Legal Representative