COKER DENTAL

William L. Coker III DDS
5500 Monument Avenue, Suite C
Richmond, VA 23226

SECTION A: THE PATIENT

Name: _____

Address: _____

Telephone: _____

Email: _____

Social Security Number:

SECTION B: ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____

Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SIGNATURE:
I attest that the above information is correct.

Signature: _____

Print Name: _____

Date: _____

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