ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Robert D. Harrington D.M.D. and Marguerite Fallon D.M.D. Notice of Privacy Practices.

Patient Name_____

Signature _____

IF THERE HAVE BEEN ANY CHANGES IN YOUR INFORMATION, PLEASE UPDATE BELOW. THANK YOU.

Address _____

Home Phone # _____ Cell _____

Employer _____

Dental Insurance Company _____