

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

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\*You may refuse to sign this acknowledgement\*

I, \_\_\_\_\_, have received a copy of  
this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but  
acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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# Periodontal Associates

OF MEMPHIS

Periodontal, Laser and Dental Implant Therapy

Roger D. Craddock, D.D.S

Mitchel S. Godat, D.D.S.

6268 Poplar Avenue  
Memphis, TN 38119

901.761.3770/800.761.1268  
Fax: 901.761.3775

**How may we contact you regarding your treatment and/or appointments?**

Home Phone: \_\_\_\_\_  
May we leave a message on your answering machine? Y or N  
May we leave a message with some one at your home? Y or N  
With Whom? Anyone/Other \_\_\_\_\_ Relationship? \_\_\_\_\_

Work Phone: \_\_\_\_\_  
May we leave a message on your voice mail at work or with an individual? Y or N  
With Whom? Anyone/Other \_\_\_\_\_ Relationship? \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Y or N  
May we leave a message on your cell phones or voice mail? Y or N

E-mail (s): May we leave a message on your e-mail account(s)? Y or N  
E-mail Address(es) \_\_\_\_\_

Is there any other way you would like to receive messages from our office? Y or N  
(I.E. other phone number, page, etc.) \_\_\_\_\_

\_\_\_\_\_  
May we contact your physician(s), Dentist, Insurance Company, etc. regarding your treatment, insurance, etc? Y or N

Thank you for assisting us in knowing the best way to reach you regarding your health care. My signature indicates that I have received a paper copy for the Privacy Practice for Periodontal Associates of Memphis.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Printed Name

Last Revised 5-3-04

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(Fill our FRONT & BACK of this page)