Dental Associates Of Shelton LLP
190 Coram Ave
Shelton,CT 06484
(203) 924-4115
(203) 924-1301

Acknowledgement of the receipt of the privacy policy notice

Patient ______________________________

Name ______________________________

Address ______________________________

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I ______________________ acknowledge that I have received a notice of the privacy policy 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 the individual ______________________

Composite Posterior Fillings

(white fillings)

Please be advised that composite fillings on the back teeth are not paid in full by your insurance company. They are paid at the silver rate by the insurance companies.There will be a balance owed by the patient on these fillings.

Patient Signature ______________________________