FERRIS STATE UNIVERSITY
College of Health Professions

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

This form documents a patient's request that the dental practice communicate with the patient in a different way or at a different place.

To the Patient: Use this form if you would like our dental practice to communicate with you other than at your primary phone number and/or address. Fill out this request in its entirety.

Patient Name (print): ____

Alternative Communication Request (Please tell us the way you would like us to communicate with you, and/or the address you would like us to use:

____
____
____

Payment Information
Your request may affect your normal billing and payment procedure. Please specify any alternative method for handling payment.

____
____

Caution: there is some level of risk that third parties might be able read unencrypted emails.

Patient Signature: ________________________________ Date: _____________________________

For Personal Representatives of the Patient

Print Name of the Personal Representative: ____

Relationship to the Patient: ____