ALABASTER SMILES
PEDIATRIC DENTISTRY
Lauri M. Williams, D.M.D., P.C.

THIS FORMS NEED TO BE FILLED OUT YEARLY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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PEOPLE AUTHORIZED TO CONSENT FOR TREATMENT:

Name: _____ **Phone No:** _____

Drivers License No: _____ **Relation to Patient:** _____

Name: _____ **Phone No:** _____

Drivers License No: _____ **Relation to Patient:** _____

Name: _____ **Phone No:** _____

Drivers License No: _____ **Relation to Patient:** _____

Name: _____ **Phone No:** _____

Drivers License No: _____ **Relation to Patient:** _____

Name: _____ **Phone No:** _____

Drivers License No: _____ **Relation to Patient:** _____

Name: _____ **Phone No:** _____

Drivers License No: _____ **Relation to Patient:** _____