

FORNI DENTAL
Max Forni D.M.D., P.A.

Today's Date: _____

I, _____, give my permission to Dr. Max Forni and the associates in his employ, including hired team members, to discuss my health and dental situation/treatments with the following persons:

Name _____

Address _____

Contact Numbers:

(work) _____ (home) _____ (cell) _____

Name _____

Address _____

Contact Numbers:

(work) _____ (home) _____ (cell) _____

This authorization shall be in effect from this day forward, and until I advise Dr. Max Forni otherwise in writing.

On this day, _____ I, (print) _____ represent that I am over the age of 18 years, I am in sound state and mind, and I am competent to enter into this agreement. I am fully aware of and understand the contents of this agreement. All my questions have been answered.

Patient's Signature: _____

Date: _____