DES MOINES RIVER DENTAL CARE

Who Do You Want To Share Information With? (Required, please do not leave blank, if you wish to share with no one, please indicate by writing "none" on each line.

Please keep in mind that this includes anyone on your behalf sharing the responsibility of:

1. Cancelling or scheduling an appointment
2. Inquiring about treatment
3. Paying a bill on my account

I give permission to Des Moines River Dental Care to share my dental history, recommended treatment, and balance information with:

______________________________ Spouse

______________________________ Parent

______________________________ Other

______________________ ________ Patient Signature & Date