

Belknap Dental Associates

40 Chestnut Street, Suite 2
Dover, NH 03820
(603) 742-4735
Fax (603) 742-9911

Personal Representative Designation Form

Instructions

Please fill out this form to appoint a personal representative to act on your behalf in discussing your dental health information and benefit coverage with Belknap Dental Associates.

Your privacy is important to us. Please take a moment to provide the requested information about yourself and the person you are designating to act on your behalf concerning your dental health. Once you return this completed, signed and dated form to us, we can verify your request, adjust our records accordingly and speak to your personal representative.

Please read this form carefully, and fill it out completely. Please print or type. If printing, please use a pen.

1 Required Information	Patient ID number:
Patient name:	Date of birth:
Patient address:	
Phone number:	Other Phone number:
Name of patient's designated representative:	
Relationship to patient:	
Representative's address:	
Phone number:	Fax number (if available):
Any limitations on issues your personal representative may discuss? If yes, please comment:	Yes No

2 Required Signatures

Personal Representative Signature _____ Date _____

Patient Signature _____ Date _____

3 Please return this completed form by mail or in person to:

Belknap Dental Associates
40 Chestnut Street
Suite 2
Dover, NH 03820
603-742-4735 b **or by fax to:** 603-742-9911

If you have any questions about this Personal Representative Designation Form, please call us.