Noble Dental Care, PLLC

69 Island St, Suite G

Keene, NH 03431

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Date of Birth: ____/____/____

By signing below, I am acknowledging that:

- ❑ I am the patient or the patient's personal representative;
- ❑ I have received a copy of the 'Notice of Privacy Practices' for Noble Dental Care, PLLC; and
- ❑ I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____ _____

Signature of the patient; parent; legal guardian/legally responsible person **Date**

_____

Relationship to patient