PHONE AUTHORIZATIONS FOR
Katherine A Kucera DDS, FAGD

Patient Name: _____

Do we have your permission to call you at

Home _____Yes _____No Phone#_____

Work _____Yes _____No Phone#_____

Cell _____Yes _____No Phone#_____

Do we have your permission to discuss you medical history and account with

Spouse _____Yes _____No Name_____

Dependant _____Yes _____No Name_____

Other _____Yes _____No Name_____
(Relationship)

Emergency contact: _____Relationship_____

Telephone: _____ Other Telephone: _____

Patient or Guardian's Signature: _____Date: _____
If a personal representative signs this authorization on behalf of the individual. Complete the following:

Personal Representative's Name: _____

Relationship to Individual:_____