



A. CHRISTOPHER BERNARDINI D.D.S.

+718 987 4040

125 Old Town Road - Staten Island, NY 10304

christopherbernardinids.com

COMMUNICATION PREFERENCES

I understand that the Doctor and team members at A. CHRISTOPHER BERNARDINI DDS may need to contact me regarding appointments, treatment, insurance or other issues related to my health. Listed below are my preferences:

Preferred language _____

Preferred method of communication: Home _____ Cell _____

Work _____ E-mail _____

Can we leave a message on machine?

Home YES NO Cell YES NO

DO NOT CALL: Home Work Cell

DISCLOSURE DESIGNATED FAMILY /FRIEND/CAREGIVER

I allow to disclosure dental/medical/financial information as needed to the following designated individual(s). I understand that I am not required to list anyone. I also understand that I may change the list in writing anytime.

Print name Date of birth Relationship Phone #

Print name Date of birth Relationship Phone #

PHARMACY

Pharmacy Name Address or Zip code Phone #

Patient Signature _____ DATE _____