HUDSON DENTAL
DR. TOM KLOSTER
2215 Vine Street
Hudson, WI 54016
(715) 386-9119

Patient Disclosure Instructions

I wish to be contacted in the following manner (check all that apply): # number in order of prefe

_____ **Home Telephone** _____

_____ Ok to leave message with detailed information

_____ Leave message with call back number only

_____ **Work Telephone** _____

_____ Ok to leave message with detailed information

_____ Leave message with call back number only

_____ **Written Communication**

_____ Ok to mail to my home address

_____ Ok to fax to number indicated _____

_____ **Cell Phone** _____

_____ Ok to leave message with detailed information

_____ Leave message with call back number only

I allow you to give my clinical information to or answer questions from, (check all that apply):

_____ Spouse _____ Parent _____ Child _____ None

_____ Other (specify): _____

_____ _____

Patient's Signature (Parent or Guardian, if minor) **Date**

_____ _____

Print Name **Birth Date**