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Notice of Privacy Policy

Last Name: _____ First Name: _____

Birthdate: _____ Date: _____

I have had full opportunity to read and consider the content of the Notice of Privacy Practices. I understand that I am giving my permissions to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Parent/Guardian Signature: _____ Date: _____