## Dental Specialties of Saint Louis University Orthodontic Clinic

## SHARING HEALTH/FINANCIAL INFORMATION

(Print name of patient)		(Birth date)	(Patient ID#)
(Street address)		(City, state, zip code)	
(Primary contact phone number) (Patient phone number)		(Primary contact email a	ddress)
other personnel ("Orthodontic of telephone, with the following facommunications regarding orth communication.	amily members or friends invo	olved in my dental care. T	his authorization is limited to
Identify below family membe	rs or others involved in your	care or payment that w	e may share information with:
Relationship			
Name			