Patient Consent to Receive Mail and/or Telephone Messages

_____

Please Print (Last Name) (First Name) (M.I.)

Do we have your permission to:

Send a recall appointment reminder to your home? Yes ___ No ___

Leave appointment, billing, or dental information on
your answering machine, voicemail, or email? Yes ___ No ___

If yes:
I give permission to share appointment, billing, or dental information with the following person(s) named below:

Name: _____ Relationship: _____

_____ _____
Signature of Patient/Parent or Legal Guardian Date

Acknowledgement of Receipt of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.
(Located on the Clipboard)

_____ _____
Signature of Patient/Parent or Legal Guardian Date