PATIENT CONSENT TO RECEIVE COMMUNICATIONS / MESSAGES

Patient Name: _____

D.O.B.: _____

I give authorization to be contacted or leave information pertaining to my care by the following methods, I assume responsibility to update this information whenever it may change.

Check all that apply:

_____ Home Phone and/or Voicemail # _____

_____ Cell Phone and/or Voicemail # _____

_____ Work Phone and/or Voicemail # _____

_____ Email: _____

_____ Other – Please Indicate: _____

List the names of people we can discuss your dental care with:

_____

NAME RELATIONSHIP PHONE NUMBER

_____

NAME RELATIONSHIP PHONE NUMBER

_____

NAME RELATIONSHIP PHONE NUMBER

_____

PLEASE PRINT NAME OF PERSON COMPLETING FORM

_____

RELATIONSHIP TO PATIENT

_____

SIGNATURE DATE