Spotsylvania Oral Surgery

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

_____

Please Print (Last Name) (First Name) (MI)

Do we have your permission to:

1. Send a dental appointment postcard to your home? Y_____ N_____

2. Leave appointment, billing or dental information on your answering machine, voicemail or email? Y_____ N_____

I give permission to share my appointment, billing or dental information with the following individual(s):_____

_____ _____

Signature of patient/parent/legal guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy or have been offered a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

_____ _____

Signature of patient/parent/legal guardian Date