SMILE
DESIGN STUDIO

## Patient Consent to Receive Mail and/or Telephone Messages

_____

*Please print* [Last Name] [First Name] [Middle Initial]

**Do we have your permission to:**

Send a recall appointment reminder to your home? Y____ N____
Leave appointment, billing, or dental information in your voicemail/email, or text? Y____ N____

I give permission to share appointment, billing, or dental information with the person named below:

Name: _____ Phone #:_____

_____ _____
[Signature of Patient/Parent or Legal Guardian] [Date]

## Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. Y____ N____

_____ _____
[Signature of Patient/Parent or Legal Guardian] [Date]