LANSDOWNE ORTHODONTICS

Patient Consent to Receive Mail and/ or Telephone Messages

Please Print

_____

Patient (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/voice mail/e-mail, text: (Please underline your preferences) ☑ Yes ☐ No

I give permission to share appointment, billing or dental information with my dentist, physician or other healthcare professional and the person(s) named below;

Full Name: Relationship to patient:

1._____/_____

2._____/_____

This consent is effective until I revoke or rescind in writing or until the end of orthodontic treatment.

_____

Signature of Patient / Parent or Legal Guardian Date

Acknowledgment of Receipt of Notice of Privacy Practices

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

_____ _____

Signature of Patient / Parent or Legal Guardian Date