GLEN BURNIE
FAMILY DENTAL

Patient Consent to Receive Mail, E-Mail, Telephone Calls and Messages

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Patient- Last Name (Please Print) | First Name | M.I.

____

Cell Phone Number | Email Address

I agree that the office staff may communicate with me electronically at the above address. I consent to receive calls and text messages related to my protected healthcare and other services at the phone number above. I understand that I may be charged for calls or text messages by my wireless carrier. Calls may be generated by an automated system.

Do we have your permission to:

Send appointment reminders and billing statements to your home? Yes _____ No _____

Leave appointment, billing or dental information on your answering machine/ voicemail/ email address? Yes _____ No _______

Consent to Share Your Dental Appointment, Billing or Health Information

In case of an emergency please contact ____.

Their phone number ____.

I give permission for any dental appointment, billing or healthcare information to be shared with the person(s) listed above.

____

Signature | Legal Guardian Name | Date

Acknowledgment of the Receipt of HIPPA Privacy Practices

I have received a copy of Glen Burnie Family Dental's Privacy Practices or I have been offered a copy and turned it down.

____

Signature | Legal Guardian Name | Date