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ST. JOSEPH MI 49085
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Telephone and Mailing Notification Consent

Patient confidentiality has always been a top priority in our office. In order to develop effective protocols to protect your privacy, we are asking you to complete this form. This will direct us as to how we can relay information from our office to you. It also instructs us as to with whom we can share information about you. Completion of this form assists us in being compliant with new state and federal regulations.

☐ YES, I give permission for office staff to leave detailed information regarding my dental appointments or care on my answering machine.

_____ at home or
_____ at work.

☐ YES, I give permission to the office staff to share any or all information concerning my appointments, prescriptions or care with the following individual (s):

☐ Physician or Specialists ☐ Immediate Family Members

☐ Spouse ☐ Insurance Carrier

☐ NO, please do not call me at home or at work to notify me of any dental treatment or appointments. I understand it will be my responsibility to contact the office for any information. I will still receive mailed reminder cards of upcoming appointments and reminder notices. I do not waive my responsibility to follow this office's established broken appointment policy.

_____

PATIENT NAME (PLEASE PRINT) DATE OF BIRTH

_____

PATIENT / GUARDIAN SIGNATURE DATE