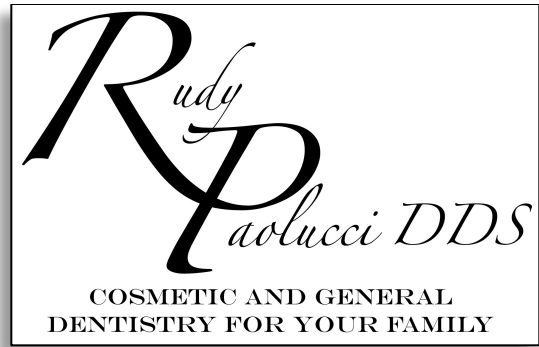


Consent to Leave Message



Patient Name: _____

Date: _____

I give permission to leave messages regarding my medical or dental health on:

(Check all that apply)

- Mobile Voice Mail
- Home Voice Mail or Answering Machine

- I do not give permission to leave a message

I give permission to leave a text message on my mobile phone regarding:

(Check all that apply)

- Appointment times
- Follow up to dental procedure

- I do not give permission to leave a text message

I give permission to leave a message about my appointment with person who may answer the telephone.

(check all that apply)

- My mobile phone
- My home phone
- My work phone

- I do not give permission to leave a message with who may answer the phone

Patient Signature

Date

Relationship if other than patient: _____