glow orthodontics
creating beautiful faces, one glowing smile at a time

Patient Consent to Receive Mail and/or Telephone Messages

(Please Print)

Patient (Last Name)	(First Name)	(Middle Initial)

Do we have your permission to:

A. Send a recall appointment reminder to your home? ❑ Yes ❑ No

B. Leave appointment, billing or dental information on your answering machine, voicemail, or email? ❑ Yes ❑ No

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

Full Name: _____

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.

Signature of Patient / Parent or Legal Guardian	Date