



# Smile Solutions Dental Center

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## Patient Contact Form

Your dentist and other staff members will at times need to contact you. By filling out the information below, we will be better able to serve you.

Name of patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

At Smile Solutions Dental Center, we have developed a policy on leaving or discussing any kind of medical information. Without your written permission,

- We will not leave messages with anyone except the patient or legal guardian
- We will not leave any information on an answering machine
- We will not leave any messages on a voicemail

I, \_\_\_\_\_ give Smile Solutions Dental Center my permission to leave a phone message regarding my medical and dental care, account information, appointment reminders, or discuss my medical and dental issues in the following methods. I fully understand that this consent will remain until revoked in writing

Patient  
Initials

\_\_\_\_\_ My home answering machine and voice mail \_\_\_\_\_  
(home/evening phone number)

\_\_\_\_\_ My cellphone voicemail \_\_\_\_\_  
(cell/other phone number)

\_\_\_\_\_ My spouse/significant other, \_\_\_\_\_

\_\_\_\_\_ My family members: \_\_\_\_\_

\_\_\_\_\_

(list name and relationship to self)

\_\_\_\_\_ Emergency contact/phone number \_\_\_\_\_  
Relationship: \_\_\_\_\_

I acknowledge I completed this form and have received a copy of the Smile Solutions Dental Center's Notice of Privacy Practices.

\_\_\_\_\_  
Printed name of Patient, Parent, or Guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date