

PATIENT CONTACT INFORMATION

Patient Name: _____

Please indicate which method of communication you would prefer and in the order of preference by circling the numbers below so that we may either speak with you directly or leave a confidential voice message:

1 2 3 _____ Ext. _____ Home _____ Cell _____ Work _____

1 2 3 _____ Ext. _____ Home _____ Cell _____ Work _____

1 2 3 _____ Ext. _____ Home _____ Cell _____ Work _____

1 2 3 Email address _____

Other: _____

Please indicate if we are allowed to leave a message with the following people:

_____ Significant Other /Name _____ Phone Number _____

_____ Relative / Name _____ Phone Number _____

_____ Friend / Name _____ Phone Number _____

_____ Assistant / Name _____ Phone Number _____

Other: _____ Phone Number _____

I consent to receive calls or a voice messages from the dental office of Scruggs & Molina Prosthodontics, for my protected oral healthcare and other services at the phone number(s) or email address indicated above.

Patient's Signature

Date