Communication Consent

Our dental office sends appointment reminders, treatment information, payment and insurance, and other communications. Please tell us your preferred method of communication.

Printed Name: _____ Date: _____

I prefer that Calhoun Clemson Dental Associates contact me via:

- ○ *Phone*
- ○ *Text*
- ○ *Email*
- ○ *Any of the above*

I authorize information about my dental health be conveyed via: (please initial all that apply)

_____ *Text*
_____ *Email*
_____ *Cell Phone*

I authorize contact from this office to relay appointment confirmation, treatment, and billing information via: (please initial all that apply)

_____ *Text*
_____ *Email*
_____ *Cell Phone*

I consent to release medical, financial, or other treatment information to the following individual(s):

Name: _____ *Relationship to Patient*: _____

Contact Phone Number: _____

- ○ Do not release my health, treatment, insurance, or billing information to anyone other than myself.

_____ _____

Signature *Date*