Ewa Awad D.D.S.
Cosmetic and Family Dentistry

PATIENT COMMUNICATION CONSENT FORM

I agree to allow Dentex Smile Studio to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Dentex Smile Studio to leave messages for me when I am unavailable.

METHOD	NUMBER/ADDRESS	MESSAGES (YES OR NO)
____Home Phone	(_____)_____	☐ Yes ☐ No
____Cell Phone	(_____)_____	☐ Yes ☐ No
____Work Phone	(_____)_____	☐ Yes ☐ No
____Alternate Phone	(_____)_____	☐ Yes ☐ No
____Text Messages	(_____)_____	☐ Yes ☐ No
____Email	_____@_____	☐ Yes ☐ No

I authorize Dentex Smile Studio and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed be low. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFO

EMERGENCY CONTACT ONLY -

NAME: _____ Phone: _____

By my signature below I acknowledge t hat I have read and understand the Guidelines to Patient Communication and information provided on this consent form. I understand the risk associated with the di fferent methods of communication, especially e-mail and texting, and consent to the conditions, restrict ions and patient responsibilities outlined with in the Guideline as well as any other instruction that Dentex Smile Studio may impose.

_____

Patient Name printed Date

_____

Patient/Authorized signature Relationship to patient

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