

Patient Communication Consent Form

Please use this form to indicate your preferences for us keeping in touch with you.

Name:

DOB:

Today’s date:

The practice can contact me by (please circle the appropriate response:

|  |  |
| --- | --- |
| Email: (enter details) | Yes/No |
| Phone: (enter details) | Yes/No |
| Text: (enter details) | Yes/No |
| I would like to receive important practice announcements and promotions | Yes/No |
| I would like to receive practice survey and feedback requests | Yes/No |
| I consent to telephone appointment reminders | Yes/No |
| I consent to text appointment reminders | Yes/No |
| I consent to email appointment reminders | Yes/No |
| I consent to messages being left with a spouse/family member | Yes/No |
| Patient’s signature |  |