



### Consent for Email and / or Text Communication

I hereby give Dreamworks Dental and Orthodontics permission to contact me in regards to confirming and scheduling appointments. Please list a valid email address and cell phone number where you would like to receive correspondence.

\_\_\_ Email \_\_\_\_\_

\_\_\_ Text (cell phone number) \_\_\_\_\_

### Consent for an individual to Access My Dental Records

I hereby give the following individual(s) permission to access and view my dental record. If I am over the age of 18, I must list the names of those individuals that I would like my dental information shares with. this includes but is not limited to spouses, parents, siblings, children, ext. Dreamworks Dental and Orthodontics will not be allowed to share information of discuss details of treatment with an unauthorized person.

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient