

MICHAEL H. ROBBINS, DDS.

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Your Name: _____ Today's Date: _____

Check and complete all that apply

☐ Contact me by U.S. Mail at the following address: _____

☐ Contact me by email at the following email address:

For Phone Communications:

Best phone number to reach you: (____) _____

☐ **By checking this box**, I consent to the following: The office of Dr. Michael Robbins may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance. The dental practice may:

☐ Call me ☐ Email me ☐ Text me- Cell Provider _____

Signature: _____ Date: _____

Please call the office right away if you get a new telephone number!

For office use only:

☐ Consent revoked. Date/Initials: _____/_____

☐ Possible reassigned number. Date/Initials _____/_____

☐ Confirmed Accurate. Date/Initials: _____/_____ Date/Initials: _____/_____

Date/Initials: _____/_____ Date/Initials: _____/_____

Date/Initials: _____/_____ Date/Initials: _____/_____