Smiles by Dr. Santos LLC

I give permission to the office of Smiles by Dr. Santos[LLC] to leave messages on my answering machine, in regard to test results or as a reminder about upcoming appointments.

_____Yes _____ No

I give permission to the office of Smiles by Dr. Santos[LLC] to discuss my personal health history with the following people. I realize that I can modify this list at any time by notifying this office in writing.

Please check ALL or ANY that apply:

( ) 1. _____ _____
Spouse Phone #

( ) 2. _____ _____
Parent Phone #

( ) 3. _____ _____
Child Phone #

( ) 4. _____ _____
Significant Other Phone #

( ) 5. _____ _____
Other and relationship to patient Phone #

Signature:_____ Date:_____

To receive our Monthly Specials, please include your Email address:

_____

703 Mill Creek Road, Suite H, Manahawkin, NJ 08050
Phone: 609-978-8466 • www.SmilesByDrSantos.com

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EMAIL RELEASE FORM

I authorize, Smiles by Dr. Santos[LLC] and its employees, to email any information necessary including Dental Records and X-Rays through our unsecured network to the places below:

_____ Within our office to different computers.

_____ To myself when requested.

_____ To other dental offices when requested.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

Witness (office staff) Signature: _____