**How would you like Broadway Dental to communicate with you?**

*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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **By checking this box, I consent to the following:** The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.

***Mail communications:***

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

Or

 Address on File

**For Phone Communications:**

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

or

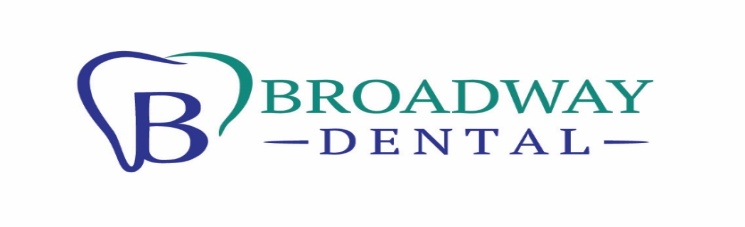
 Numbers on file

**Let us know if you would like your appointment reminder via text message**

* Text number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please call the dental office right away if you get a new telephone number or change of address!***



**Consent to Obtain Patient Medication History**

Patient medication history is a list of prescription medicines that our practice providers, or  other providers, have prescribed for you. A variety of sources, including pharmacies and health  insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR)  and becomes part of your personal medical record. Medication history is very important in  helping healthcare providers treat your symptoms and/or illness properly and in avoiding  potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure  that your recorded medication history is 100% accurate. Some pharmacies do not make drug  history information available, and your drug history might not include drugs purchased without  using your health insurance. Also over‐the‐counter drugs, supplements, or herbal remedies that  patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from  my pharmacy, my health plans, and my other healthcare providers.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

     Patient  Signature , Parent /Guardian (if patient under 18) Date

              By signing this consent form you are giving your healthcare provider permission to collect and  giving your pharmacy and your health insurer permission to disclose information about your  prescriptions that have been filled at any pharmacy or covered by any health insurance plan.  This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental  health issues such as depression.