## **Portland Smiles**

## **Patient Communication Form**

Patient's Legal Name:	Date of Birth:		
First	MI	Last	
Parent(s)/ Legal Guardian(s):			
Mailing Address:			
Email Address:			
Phone Contacts		<u>Circle One</u>	<u>Circle One</u>
☐ Home ☐ Cell ☐ Work	Okay to leave	message? Yes/No	**Extended Message? Yes/No
☐ Home ☐ Cell ☐ Work	Okay to leave	message? Yes/No	**Extended Message? Yes/No
Email Contacts		<u>Circle One</u>	Circle One
Email Address:	Okay to leave	message? Yes/No	**Extended Message? Yes/No
Email Address:	- Okay to leave -	message? Yes/No	**Extended Message? Yes/No
Text Message Contacts		Circle One	Circle One
☐ Cell	Okay to leave	message? Yes/No	**Extended Message? Yes/No
Cell	Okay to leave	message? Yes/No	**Extended Message? Yes/No
*:	*Extended messag	ges may contain dent	al and/or prescription information
☐ I do <u>not</u> want any information☐ I give Portland Smiles permiss			o family members/caregivers. members/caregivers listed below
Name:	Name:	Nam	e:
Please check the box next to the individual(s) listed above:  ☐ Treatment information ☐ Bill Information		·	
This authorization will be update writing at any time. Revocation v	•	_	
Patient/Parent/Legal Guardian S	ignature		 Date