



BAY COSMETIC DENTISTRY
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CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

Patient Name

Do we have your consent to:

Send recall appointment reminders in the mail? Yes No

Leave appointment, billing, or dental information on your answering machine, voicemail, or email? Yes No

Share your appointment, billing, or dental information with another individual? Yes No

If yes, please list their name(s) here:

Signature of patient (or parent/guardian if minor)

Date