

**Silas E. McAninch, DDS, PA**  
**Pediatric and Adolescent Dentistry**

**Patient Consent to Communication Delivery Method**

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*Please print* (Last Name) (First Name) (M.I.)

**Do we have permission to:**

Send a recall appointment reminder postcard to your home? Y \_\_\_\_\_ N \_\_\_\_\_  
Leave the following information on your home answering device (check all that apply):

- Appointment information
- Billing information
- Dental information

Leave the following information on your work answering device (check all that apply):

- Appointment information
- Billing information
- Dental information

I give permission to share appointment information with the person/s named below:

Name: \_\_\_\_\_

I give permission to share billing information with the person/s named below:

Name: \_\_\_\_\_

I give permission to share dental information with the person/s named below:

Name: \_\_\_\_\_

Do we have permission to send x-rays and/or relevant, dental information to other dental/medical professionals of your choosing? Y \_\_\_\_\_ N \_\_\_\_\_

I give permission for the Dentist or designated staff member to discuss relevant information:

- At the business office desk
- In the treatment area
- In the waiting area
- All of the above
- Special request \_\_\_\_\_

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Signature of Patient or Patient Representative

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Date