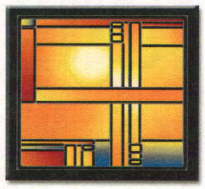

Gainesville Family Dentistry, PC

Matthew T. Record, D.D.S. & Risa M. Record, D.D.S.

212 South Grand Avenue

Gainesville, TX 76240

Ph: (940)665-4761

Fax: (940)665-0199

Patient Name: _____

Patient Address: _____

_____

Date of Birth: _____

Daytime Phone: _____ (Hm/Wk/Cell)

Confidential Voicemail Authorization

From time to time in caring for our patients, it may become necessary to contact you by telephone. In the event that you are not available to answer when we call, we would like to be able to leave detailed telephone messages regarding your care. If you would like us to provide this service, please complete the authorization below, and list the telephone number(s) at which you would like to receive messages regarding your treatment.

I,_____, give Gainesville Family Dentistry and their staff my permission to leave confidential messages regarding my treatment on the following voicemail machines:

☐ **My home or cell phone** **Telephone Number:**_____

☐ **My spouse's (name)** _____ **Telephone Number:**_____

☐ **Other (name)** _____ **Telephone Number:**_____

_____ _____ _____

Patient's Printed Name **Patient's Signature** **Date**

_____ _____ _____

***Legal Representative's Printed Name** **Legal Representative's Signature** **Date**

_____

***If representative, specify relationship to patient**

_____ _____

Witness **Date**