

Dear Valued Patient **Patient Name:** _____

We are in the process of improving our appointment confirmation and communication with our patients by implementing an internet based program. The new program is called **Smile Reminder**. This system will enable you as our patient to receive appointment reminders, appointment availability, online payments, newsletters, promotions, and other special offers from our office by **Text and/or Email**. We would appreciate your help by updating your contact information for this state of the art system. Hopefully, this new program will benefit us all, with faster and simpler communications.

Email: _____

Cell #: _____

I prefer to be contacted by _____ **Email** _____ **Text** _____ **Both**

If you would prefer **not** to be contacted in this way, provide us with your home phone number only. **Home #:** _____

Patient/Guardian Signature: _____

PHOTOGRAPHY CONSENT FORM / RELEASE

I, (print name) _____, hereby grant permission to Jones Family Dentistry, to take and use: photographs and/or digital images of me for use in news releases and/or educational materials. These materials might include printed or electronic publications, Web sites or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions shall be the property of Jones Family Dentistry.

_____ **(Date)**

_____ **(Signature of adult)**

RELEASE FOR MINOR CHILDREN (Under 18)

I, (print name) _____, parent or official guardian of (child's name) _____ hereby grant permission to Jones Family Dentistry, to take and use: photographs and/or digital images of my child for use in news releases and/or educational materials as follows: printed publications or materials, electronic publications, or Web sites. I agree that my child's name and identity: may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions and shall be the property of Jones Family Dentistry.

_____ **(Date)**

_____ **(Signature of Parent or Guardian)**