Northshore Endodontics, P.C.
John E. Sullivan Jr., D.D.S., M.S.

Consent For Healthcare Messages

I____D.O.B.______________
give permission to Dr. Sullivan and his staff to leave messages regarding my healthcare in the following manner when I am not available:

_____May **ONLY** leave information with me. **(If you check here, no other choices should be marked, skip to the Contact Information section below).**

Please mark all that apply – if you checked the line above then these should be blank.
_____May leave appointment reminders on my answering machine / voice mail.
_____May leave general questions / information on my answering machine / voice mail.

If any are checked below, please list the name of the individual we may give information to:
_____May leave appointment reminders with the following person(s).
_____May leave general questions / information with the following person(s).

Name:____ Relationship:______________
Name:____ Relationship:______________

Contact Information:
I would prefer to be contacted at:

Home_____ Phone #________________________
Cell _____ Phone #________________________
Work _____ Phone #________________________

____ __________________
Patient or Guardian Signature Date

____ __________________
Witness Signature Date