

## Agreement to Receive Electronic Communication

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**(Initial below)**

I \_\_\_\_\_ DO AGREE

I \_\_\_\_\_ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

**(Initial below)**

\_\_\_\_\_ Text Messaging

\_\_\_\_\_ Email

I would like to receive:

\_\_\_\_\_ Appointment Reminders/Recall Visits

\_\_\_\_\_ Information regarding insurance/billing

\_\_\_\_\_ Requests for Patient Satisfaction online reviews

**I can withdraw my consent to electronic communications at anytime by calling:**

**INSERT YOUR OFFICE NAME | PHONE NUMBER | OFFICE EMAIL ADDRESS:**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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