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 phone number listed below.	with me electronically at the email address and/or mobile
	hat third parties might be able to read unencrypted emails. riding the dental practice any updates to my email address
My most preferred method of electronic co	mmunication:
(Initial below)	
Text Messaging	
Email	
I would like to receive:	
Appointment Reminders/Recall Visits	
Information regarding insurance/billing	g
Requests for Patient Satisfaction onlin	e reviews
I can withdraw my consent to electronic co	ommunications at anytime by calling:
INSERT YOUR OFFICE NAME PHONE NUMI	BER OFFICE EMAIL ADDRESS:
Patient Signature:	Date:

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