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.

I_____ DO NOT WANT to receive Patient Satisfaction Online Reviews to my e-mail.

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

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

Fantastic Family Dental

(408)819-3443

drlin@FantasticFamilyDental.com

Patient Signature: _____ Date:_____