



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.

Preferred Phone # \_\_\_\_\_

Email \_\_\_\_\_

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

\_\_\_ Both/Either

*I would like to receive:*

\_\_\_ Appointment Reminders/Recall Visits

\_\_\_ Information regarding insurance/billing

\_\_\_ Request for Patient Satisfaction online reviews

**I can withdraw my consent to electronic communications at any time by calling:(414)427-8565**

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

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