KRAKLOW
QUALITY DENTISTRY

Agreement to Receive Electronic Communication Patient

Name:_____Date of Birth:_____

(Intial 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:_____