Electronic Communication Consent Form

Patient's Full Name: _____ Date of Birth: _____
(Please initial below)

I _____ AGREE to receive electronic communications.

I _____ DO NOT AGREE to receive electronic communications.

I understand and acknowledge that by agreeing to electronic communication, the dental practice may contact me via email and/or mobile phone number provided below. I am aware of the potential risks associated with unencrypted emails being intercepted by third parties. Furthermore, I accept responsibility for promptly updating the dental practice with any changes to my contact information.

Preferred Method of Electronic Communication: (Please 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 reserve the right to withdraw my consent to electronic communication at any time by contacting the office at INSERT YOUR OFFICE NAME|PHONE NUMBER|OFFICE EMAIL ADDRESS.

Patient's Signature: _____ Date: _____