AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

Patient Name: _____ DOB: _____

I agree the dental practice may communicate with me electronically at the e-mail address listed below.

I am aware there is some level of risk that third parties might be able to read unencrypted e-mails.

I am responsible for providing the dental practice any updates to my e-mail address.

I can withdraw my consent to electronic communication by calling:

603.895.5600

E-mail address (Please print clearly)

_____ @ _____

Patient signature_____

Date:_____