Delray Family Dentistry

15300 JOG RD STE 207 | DELRAY BEACH FL, 33446 | (561) 498-3181

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.

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

____ Requests for Patient Satisfaction online reviews

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

INSERT YOUR OFFICE NAME | PHONE NUMBER | OFFICE EMAIL ADDRESS:

Patient Signature:____ Date:______________________

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