Agreement to Receive Electronic Communication

Patient Name_____Date of Birth_____

(initial below)

I DO AGREE_____

I DO NOT AGREE _____

That the dental office may communicate with me electronically at the email address
and/or mobile phone number listed below.

I would like to be contacted by:

___ Text Message_____(cell phone number)

___ Email Message_____(email address)

___I would like to be contacted by BOTH email and text message reminders

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.

Patient Signature:_____ Date: _____

You can withdraw consent to electronic communications at any time by contacting our office or calling:

619-283-6381 or info@laserimplantdental.com