

JAMES STREET D E N T A L

Agreement to Receive Electronic Communication

Patient Name: _____ **DOB:** __/__/_____

Please check one below:

I AGREE

I DO NOT AGREE

That James Street Dental, PC may communicate with me electronically at the email address and/or mobile number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. We will never put full name, SS number, insurance information, or payment information in an unencrypted email. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile number.

Please check below if you consent to communicate via (may check both):

Text Messaging

Email

Which method would you prefer? Text Messaging Email

I would like to receive:

Appointment Reminders/Recall Visits

Information regarding insurance/billing

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

James Street Dental, PC

630-232-9535

Jamesstreetdental@yahoo.com

Patient Signature: _____ **Date:** _____

Mobile Number: _____

Email: _____