

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth: _____

I agree that the dental practice may communicate with me electronically at the email address below.

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

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling 773.282.9696.

Email Address (PLEASE PRINT CLEARLY):

_____ @ _____

Patient Signature: _____

Date: _____

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Request for Confidential Communications

To the Patient: Use this form if you would like our dental practice to communicate with you other than at your primary phone number and/or address. Fill out this request in its entirety.

Patient Name (*print*): _____

Alternative Communication Request (Please tell us the way you would like us to communicate with you, and/or the address you would like us to use):

Payment Information

Your request may affect our normal billing and payment procedure. Please specify your alternative method for handling payment.

Caution: there is some level of risk that third parties might be able to read unencrypted emails.

Signature of Patient: _____ Date: _____

For Personal Representatives of the Patient

Print Name of Personal Representative: _____
Relationship to the Patient: _____