

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 communication by calling: 828.277.6868.

Email Address (PLEASE PRINT CLEARLY)

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_