Patient Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth:_____

I agree that the Center for Dental Excellence 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 with any updates to my email address.

I can withdraw my consent to electronic communications by calling: **(860) 658-1991**

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient Signature: _____

Date: _____