Peddicord Family Dentistry, PLC

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth: ____/____/_____

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

____I DO AGREE

____I DO NOT AGREE

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 address and/or cell phone number.

I can withdraw my consent to electronic communications by calling: **(515) 963-3339**

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Mobile #: (_____) _____-_____

Patient Signature: _____

Date: ____/____/20_____